PRINTED: 10/31/2007 FORM APPROVED OMB NO. 0938-0391

| CENTE | RS FOR MEDICARE | & MEDICAID SERVICES | | | OMB NO | <u>. 0938-0391</u> |
|--------------------------|--|---|---------------------|--|---|----------------------------|
| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DELAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MUL | TIPLE CONSTRUCTION | (X3) DATE SURVEY | |
| | | BENTH IONNION HOMBEN. | A. BUILDI | NG | COMPLE | : IED |
| | | 09G058 | B. WING | · · · · · · · · · · · · · · · · · · · | 10/1 | 2/2007 |
| NAME OF F | ROVIDER OR SUPPLIER | | rs s | REET ADDRESS, CITY, STATE, ZIP COI | | ZIZOUT |
| SYMBRA | AL | , | | 521 KENNEDY STREET, NE WASHINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X6) COMPLETION DATE |
| W 104 | Surveyor: 17815 A recertification sur October 10, 2007 to survey was initiated. A random sample of from a resident popularious disabilities, focused review of the and psychotropic infindings of the surveyobservations, intentite home and at two one client's medical of client and adminincident reports. 483.410(a)(1) GOV. The governing bod | rvey was conducted from hru October 12, 2007. The dusing the full survey process. of two clients was selected outlation of four men with A third client was added for a his behavior management plan hedication regimen. The rey were based on views with clients and staff in vo day programs, interview with all guardian, as well as a review istrative records, including | W 000 | ensure that documents/ placed within the indivi- concerning habilitation and life-changing issue policy will be reviewed and PRN basis. QA will semi-annual audits to e compliance. QMRP will monitor qu | records are idual files, medical s. This on annual ll conduct nsure | 11/30/07 |
| | Surveyor: 17815 Based on observat review, the facility's general operating of except in the follow The findings includ 1. Cross-refer to V approximately 1:15 Qualified Mental R (AQMRP) indicated guardian was notifit | | | | 3 | |

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

and record review, however, revealed no

TITLE

(X6) DATE

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

TATEMENT OF DEFICIENCIES

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDIN | l co | (X3) DATE SURVEY COMPLETED | |
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| | | 09G058 | B. WING_ | | 40/40/0007 | |
| SYMBRA | ROVIDER OR SUPPLIER | | 5 | REET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | 10/12/2007 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE | |
| W 104 | and implemented p ensure that clients' were informed of the and attendant risks document this review. 2. Cross-refer to Week and implemented personal properties. | overning body had established olicies and procedures to court-appointed guardians e client's medical condition of treatment, and to properly with the clients' records. | W 104 | 2 (| | |
| | failed to establish a procedures that spe document each cor | nd implement policies and ecified how facility staff should atact and/or communication l/or involved family members) | | 2. Cross refer to W143 and adopted.3. Symbral will develop a protocol to ensure that individual have access to t funds for personal use. | | |
| | failed to ensure that policies and proced of clients' court-application incidents and/or characteristics. 4. Cross-refer to Walled to ensure clients. | /148. The governing body t the facility implemented its ures regarding the notification ointed guardians of significant anges in the clients' condition. /136. The governing body nt access to their personal preferred recreational outings | | 4. Governing body will ensure that al staff involved in transporting individu will be trained prior to providing service to the individual. House Manager and QMRP will provide reviews with staff. | als | |
| | such as dancing at theatre productions opportunity to partic activities. 5. Cross-refer to W failed to establish a | nightclubs and attending live, or otherwise ensured client sipate in social and community /149.5. The governing body and implement an effective to ensure client safety during | | 5. Symbral will develop a transportat /safety review form to document staff training. Oneness Mobility Services v conduct staff training and train the trainer. | , | |
| | transportation. Clie properly secured whim the community. It staff indicated that the and therefore were properly. | ont #1's wheelchair was not in the facility van while straps were available, they had not received training unaware of how to use them | | | : | |
| | b. Cross-refer to W | /159. The governing body | | | | |

(X1) PROVIDER/SUPPLIER/CLIA

TATEMENT OF DEFICIENCIES

PRINTED: 10/31/2007 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

| D PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | · | COMPLETED | |
|---|--|---|---------------------|--|------------------|
| | | 09G058 | B. WING | | 10/12/2007 |
| AME OF P | ROVIDER OR SUPPLIER | | 52 | EET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLÉTION |
| W 104 | failed to ensure con supports and service consistent implement | nge 2 Intinuity of QMRP reviews, It is a second and entation of client programs and the previous 12-month | W 104 | 6.Governing body will ensure that Ac Treatment Services are provided and for individuals served. QA will monit quarterly.Cross refer to W159 and ad | updated or |
| W 111 | failed to ensure tha | | W 111 | Governing Body will ensure that the receive training on proper implemental documentation of individual programs | tion and |
| | recordkeeping syst | evelop and maintain a tem that documents the client's treatment, social information, ne client's rights. | | | |
| | Surveyor: 17815 Based on interview facility failed to mathat contained all p | is not met as evidenced by: and record verification, the intain a record keeping system pertinent client information in es, for two of the two clients in ets #1 and #2) | | | |
| | medical chart reversible Nurse Note, dated the following: "5/28 seizure activity." Note that the monature of the seizure from May 28, 2007 | Je: 2007, review of Client #1's saled a May 2007 Monthly May 31, 2007, that included 3/07 emergency room visit for No additional information was nthly note to describe the Ire. A Nursing Progress Note 7 indicated: "seizure activity tes. Consumer was taken to | | | |

(X2) MULTIPLE CONSTRUCTION

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 09G058 | B. WIN | G | | 10/1: | 2/2007 | |
| NAME OF F | ROVIDER OR SUPPLIER | | J.,,, | 52 | EET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE (ASHINGTON, DC 20011 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | 1 | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLO BE | (X5) COMPLETION DATE | |
| W 111 | discharged 4 AM records during the that staff who were his seizure had do symptoms on a sei accordance with as lt should be noted (post-survey), the tafax transmittal thitems, a seizure re 5/2 <sic> and descand symptoms of a experienced. Furta space designate been signed by the faxed materials did</sic> | " Further review of the client's survey failed to show evidence with Client #1 at the time of cumented the signs and izure report form, in | W | 111 | Staff will be inserviced on documentation of episodes of seizures activity. House Man will ensure that report is comprior to the staff and transfer the nurse, unless the individual required emergency room intervention, medication nurse charge nurse will complete protes as soon as possible, but later than 24 hours and filed individuals medical records. Charge nurse will review on monthly basis. Director of N will review quarterly. QMRF QA will monitor to ensure | ager apleted and al ase or arogress at not in the a | 11/30/07 | |
| | 2007, review of Cline had been seen and undergone did had surgery on a homost recent GI ap August 21, 2007. additional tests had documented approacher items, a diag 20, 2007 that had at the time of the stat Client #2 under examination on Seradiology clinic. A | M124.4.c. On October 12, ient #2's record revealed that by GI specialists several times, agnostic procedures, since he niatal hernia in June 2006. The pointment documented was on It was later determined that d occurred but had not been opriately in the client's record. 207, the facility sent to the State smittal that included, among pnostic report dated September not been in the client's record survey. The report indicated erwent an upper GI series eptember 20, 2007 in a hospital cross the top of the diagnostic ctronic stamp' indicating that it | | | | | | |

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIE A. BUILDING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|----------------------------|---|--|----------------------------|
| | | 09G058 | B. WING | | 10/1 | 2/2007 |
| IAME OF PI | ROVIDER OR SUPPLIER L | <u> </u> | 5: | EET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE /ASHINGTON, DC 20011 | | 2/2001 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| W 111 | (October 16, 2007 procedure was per lt should be noted notations added to report. Whoever | cility earlier that same day '), almost 1 month after the | W 111 | 2. Director of Nursing will ensure that all reports are followed up, reviewed, filed individuals book. Director of Nursing will ensure that revie (Nurses, Doctors) sign and date docume Charge Nurse will review medical files q ensure that results of labs and diagnostic properly filed and ready for reviews. DON and QA will monitor to ensure con Cross references W124-4.c and adopted. | in the ewers nt. uarterly to tests are | 11/30/2007 |
| W 112 | The facility must be contained in the offerm or storage must be form or storage must be contained in the contained in each four clients residing. The finding included the client foods that he was medical conditional the confidentiality information. It should be noted 7:51 AM, review of Procedures Manaconfidentiality of includentiality of including the confidentiality information. | teep confidential all information lients' records, regardless of the method of the records. is not met as evidenced by: ation and staff interview, the eep confidential all information of client's record, for one of the ng in the facility. (Client #2) | W 112 | QMRP will ensure individuals' information is no longer posted that violate their privacy and confidentially, staff will be inse individual records and informat protection of confidential. Any information that need to b which is confidential but must accessible area, will have the in initials instead of the full name, and QA will monitor to ensure compliance. | rviced on ion e seen be in an dividual | 11/30/07 |

| ND PLAN O | F CORRECTION | IDENTIFICATION NUMBER: | A. BUI | | | (X3) DATE SU COMPLE | |
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| | <u> </u> | 09G058 | B. WI | NG | | 10/1: | 2/2007 |
| SYMBRA | ROVIDER OR SUPPLIER L | | - 1 | 5 | REET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| W 112 | the confidentiality information at coll destruction stages 483.420(a)(2) PRIRIGHTS The facility must experience the facility must experient (if the client of the client's mediand behavioral stages) | of personally identifiable ection, storage, disclosure and | | 1124 | semi-annual meeting and forward to guardian. QMRP will forward to leguardian on a quarterly progress no communicate on an as need basis of medical updates, treatment process procedures. Records will be kept windividuals file on the transfer of the via Communication Transmission | to legal egal ote and on and within the nis report Log. | 11/30/07 |
| | Surveyor: 17815 Based on intervier facility failed to en legal representation medical condition one of the two clies. The findings inclused During the October conference, at ap House Manager in court-appointed gresented the clies dated April 5, 200 medical purposes October 12, 2007 client's medical chappointing the medical chappointing the medical court-appointing the medical chappointing the | is not met as evidenced by: w and record verification, the sure the right of each client's ve to be informed of the client's and proposed procedures, for ents in the sample. (Client #2) de: er 11, 2007 entrance proximately 11:20 AM, the adicated that Client #2 had a uardian. Moments later, he ent's Individual Support Plan, 7, in which the guardian "for enly" was documented. On at 2:01 PM, review of the part revealed a court document edical guardian, effective July | | | Guardian will be requested to trans notes confirming receipt of inform QMRP and QA will monitor to er compliance. | ation. | |

PRINTED: 10/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE **SYMBRAL** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID in PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) W 124 Continued From page 6 W 124 dated July 19, 2006, revealed "a couple of hospitalizations for gastric problems" during the previous year. The quardian's most recent documented visit to the facility was June 25. 2006. The client's medical chart revealed that he had undergone surgery in June 2006 to repair a hiatal hernia, and had a history of GI bleeding, mild esophagitis, Barrett's esophagus syndrome and left sided colitis. Further review of the client's record revealed the following: 1. Client #2 had an ultrasound procedure of the abdomen performed on October 5, 2006. 2. He had undergone upper GI tests on October 24, 2006. This was 3 months after the last documented contact by the facility to the medical guardian. The corresponding report revealed that the findings had been "limited" due to the "patient could not follow commands and did not wish to drink the barium." [Note: They were, however. able to view some of his system and no new problems or diagnoses were indicated.] 3. Case conference was held on December 7. 2006 at which time some members of his interdisciplinary team met to review 3 reports prepared by an outside entity regarding his nutritional intake and the use of Boost nutrition supplement three times daily. Further review of the case conference documents failed to show evidence that the medical guardian (1) had been in attendance, (2) had been invited to participate, and/or (3) would be informed of the team's decisions following the case conference.

4. The former House Manager documented a June 14, 2007 visit to a GI clinic at which time the doctor refused to provide services and referred

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 124 Continued From page 7 W 124 Client #2 back to the doctor who had performed the hernia operation in June 2006. The House Manager's note did not indicate notification of the medical guardian and no other evidence of such notification was evidenced in the client's record. 5. At approximately 6:30 PM, further review of Client #2's medical chart revealed documented visits to GI consultants on June 26, 2007 (recommended "GI medicine to evaluate") and on August 21, 2007 (reflected "episodes of vomiting in June..." and recommended "patient should have head of bed elevated" and a "barium swallow study with upper GI series..." The client's record did not, however, reflect any communications with the medical guardian regarding these consultations and/or recommended treatments and diagnostic procedures. It should be noted that one of the GI specialists contacted by the facility since then had refused to serve the client because he no longer accepted DC Medicaid insurance. 6. On October 12, 2007, at approximately 1:15 PM, interview with the Acting Qualified Mental Retardation Professional (AQMRP) indicated that Client #2's medical guardian was notified of the client's medical issues and team meetings. Further interviews and record review, however. revealed no evidence that the facility had established a policy and procedure that specified how facility staff should document each contact and/or communication with guardians (and/or involved family members).

7. On October 16, 2007, the facility sent to the State agency a fax transmittal that included, among other items, a diagnostic report dated September 20, 2007 that had not been in the

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BU | | PLE CONSTRUCTION G | (X3) DATE S | |
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| IAME OF P | ROVIDER OR SUPPLIER | | | 5 | REET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | 10/1 | 2/2007 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | ıx | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| W 124 | client's record at the report indicated the upper GI series exponding of the control of the following: "More distal esophageal upper endoscopy: 8. A telephone into the record of the control of the cont | ne time of the survey. The at Client #2 underwent an camination on September 20, radiology clinic due to "nausea e report's conclusion included derate sized hiatal hernia with stricture. Would recommend to correlate further." | W | 124 | | ÷ | |
| W 130 | guardian on October 15, 2007, at 2:20 PM, revealed that he had not been notified of the client's medical consultations or health status during the past 12 months. 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. W 130 Director of Nursi on privacy in the medications and Nursing monitor the next 90 day a | | Director of Nursing will inserviced on privacy in the administration of medications and treatments. Direct Nursing monitor the delivery of set the next 90 day and will conduct reproficiency audit on this practice. | tor of rvice over | 10/16/07 and ongoing | | |
| , | Surveyor: 17815 Based on observa implement an effe clients' rights for p administration, for residing in the faci | is not met as evidenced by: tion, the facility failed to ctive system to protect the rivacy during medication three of the four clients lity. (Clients #1, #2 and #4) | | | | | |
| | October 10, 2007, medication nurse of to privacy during the medications, as for | cation pass was observed on beginning at 5:50 PM. The did not protect the clients' right ne administration of | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **521 KENNEDY STREET, NE** SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 130 Continued From page 9 W 130 observed administering medications to Client #4 at the dining room table while 1 of his peers sat next to him at the table. The client received Zyprexa and Lactulose: 2. at 6:13 PM, the nurse was observed administering medications to Client #1 in the dining room, while 2 of his peers sat at the table. The client received Depakote by mouth and Nasonex nasal spray to each nostril; and, 3. at 6:23 PM, the nurse was observed administering medications to Client #2 at the dining room table while 3 of his peers sat at the table. The client received Terazosin and Reglan by mouth and baby oil was applied to both ears. W 136 483.420(a)(11) PROTECTION OF CLIENTS W 136 QMRP will ensure that individual #2 and all RIGHTS 12/15/07 other individuals supported will participate The facility must ensure the rights of all clients. in recreational/community/social activities Therefore, the facility must ensure that clients of choice. House Manager will ensure that have the opportunity to participate in social, funds are made available and individuals religious, and community group activities. participated in such activities by requesting funds when necessary from the administration in a timely manner. The This STANDARD is not met as evidenced by: House Manger will provide a month Surveyor: 17815 calender of the activities planned and Based on client and staff interviews and record preferred and communicate any barriers verification, the facility failed to provide which prevented individualized opportunities to participate in community outings participation. QMRP will follow up with of choice, to meet the needs of two of the two House Manager to resolve issues and clients in the sample. (Clients #1 and #2)

The findings include:

1. The facility failed to ensure Client #1 was afforded the opportunity to attend live theatre (musicals and plays) in accordance with his assessed interest, as evidenced by the following:

ensure the individual participation in preferred recreational activities. OA will

monitor quarterly to ensure compliance.

| TATEMENT OF DEFICIENCIES (X1) PROVIDENT IDENTITION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| · | | 09G058 | B. WING | <u> </u> | 10/1 | 2/2007 |
| SYMBRA | ROVIDER OR SUPPLIER | | 52 | EET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE (ASHINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| W 136 | PM, review of Clier (ISP), dated March following statemen theatre enjoys must of his IPP revealed for him to "participal recreational activitifurther review of the failed to outline pot choice. Review of recreational activitie evidence that he has the previous 12 modes. At 5:04 PM, the bedroom. He confattending live theat had the opportunity c. At approximatel recently-hired Hous was unaware of hos selected. d. At 7:19 PM, intestaff persons reveal going to the Chates inghts. His record outlings to the Chates staff acknowledged the Chateau was decently to that since the Marc Chateau, requests personal funds to person | 2007, at approximately 4:10 nt #1's Individual Support Plan 21, 2007, revealed the ton page 7: "Love going to the sicals as well as plays." Review a service objective in his IPP ate in a minimum of 4 es per month." However, e program revealed that it tential recreational activities of the client's community outings/ es record revealed no ad been to a live theatre during onths. client was interviewed in his irmed that he enjoyed are performances but had not | W 136 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G058 NAME OF PROVIDER OR SUPPLIER 10/12/2007 STREET ADDRESS, CITY, STATE, ZIP CODE SYMBRAL 521 KENNEDY STREET, NE WASHINGTON, DC 20011 (X4).ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 136 Continued From page 11 W 136. OMRP will ensure that individuals have the not been acted upon by administrators at the 12/15/07 opportunity to participate in different corporate office. Review of the client's and documented outings revealed that they consisted events/ activities if they choose to. OMRP ongoing of outings to parks, supermarkets, shopping malls will monitor implementation for specific and/or driving past monuments and government preferences (religious, cultural, social buildings ("sightseeing"), all at no cost. provided.) Subsequent review of the client's financial records for the 9-month period December 31, QA will monitor on a quarterly basis to 2006 - September 28, 2007 revealed that except ensure compliance. for a 6-day vacation to Ocean City, MD at the end of July 2007, the client had not spent any personal funds for anything, community outings included. (Note: According to a bank statement dated September 28, 2007, his bank balance was more than \$1,000.) 2. On October 12, 2007, review of Client #2's record of community outings revealed a listing of group outings that consisted of the same activities documented for Client #1, namely parks, supermarkets, shopping malls or driving past monuments and government buildings. His record did not reflect individualized outings of personal choice and no recent opportunities to attend social, religious or community group activities. 483.420(c)(1) COMMUNICATION WITH W 143 W 143 CLIENTS, PARENTS & The facility must promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

Surveyor: 17815

This STANDARD is not met as evidenced by:

Based on interviews and record verification, the

| | F CORRECTION | IDENTIFICATION NUMBER: | A. BUILDING | | COMPL | |
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| | | 09G058 | B. WING | G | 10/ | 12/2007 |
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| members and/or legal guar | | omote the participation of family legal guardians in the active s, for two of the two clients in the #1 and #2) | W 14 | Cross reference to W124 | l and adopted, | 11/30/07 |
| | conference, at ap House Manager in foster mother rem treatment plannin October 12, 2007 telephone intervier revealed that an "Support Plan (ISF family members a reportedly sent rethe meeting and that the formal means for with family membolients' records. (PM, review of the (ISP), dated Marcindication that the annual meeting. | proximately 11:20 AM, the indicated that Client #1's former nained involved in the active ing and review process. On a proximately 1:20 PM, with the Acting QMRP annual calendar" of Individual meeting dates was sent to and guardians. The facility eminder letters 90 days prior to then telephoned them within 30 ing. Further interview, however, facility had not established a documenting these contacts pers and/or guardians in the On October 12, 2007, at 4:05 eclient's Individual Support Plan ch 21, 2007, revealed no efoster mother had attended the Further review of the client's | | | | |
| | mother had been other interdiscipling PM, Client #1 states his foster mother Thanksgiving. Ditime confirmed the This surveyor was that the foster module calendar, 90 day | how evidence that the foster invited to the March 21, 2007 or nary team meetings. At 5:05 ated that his most recent visit with had been the previous irect support staff present at the nat this had been his last visit. It is unable to verify in the record other had received the ISP reminder letter or received or promote her participation in the | | | | |

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| W 143 | planning and reviev | v process. | W 143 | W143 1 a-c Cross reference W12 adopted. | 24 and | 11/30/07 | |
| | court-appointed gu purposes only." T promote the guardi interdisciplinary tea | V124. Client #2 had a ardian assigned "for medical he facility, however, failed to an's participation in the am process, as follows: 2007, review of the client's | | | | | |
| | record revealed the conference held on time some membe met to review 3 repentity regarding his of Boost nutrition s Client #2's medical visits to GI consulta (recommended "GI | ere had been a case December 7, 2006 at which rs of his interdisciplinary team orts prepared by an outside nutritional intake and the use upplement. Further review of chart revealed documented ants on June 26, 2007 medicine to evaluate") and on | | | | | |
| • | August 21, 2007 (reflected "episodes of vomiting in June" and recommended "patient should have head of bed elevated" and a "barium swallow study with upper GI series" The client's record did not, however, reflect any communications with the medical guardian regarding these consultations and/or recommended treatments and diagnostic procedures. | | | | | | |
| | guardian was interview revealed interview revealed interview revealed in was previously una | 2007, at 2:20 PM, the medical viewed by telephone. The that, among other things, he ware that a case conference on the first section. | | | | | |

c. Interviews and record review revealed no

evidence that the facility had established a policy and procedure that specified how facility staff should document each contact and/or

PRINTED: 10/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY NO PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID IΩ PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 143 Continued From page 14 W 143 communication with guardians (and/or involved family members). 483.420(c)(6) COMMUNICATION WITH W 148 Cross refer to W124 and adopted. Any 11/30/07 CLIENTS, PARENTS & unusual incident that involves major medical or emergency room visits will be The facility must notify promptly the client's communicated to the medical guardian and/ parents or guardian of any significant incidents, or changes in the client's condition including, but not or family representative. Communication limited to, serious illness, accident, death, abuse, tracking log will be completed and or unauthorized absence. confirmation documentation will be placed within the individuals files. (confirmation note from the recipients, faxes, certified This STANDARD is not met as evidenced by: mail, signature receipt form) Surveyor: 17815 Based on interview and record verification, the facility failed to notify clients' legal guardians of significant changes in health condition and/or incidents involving injuries, for the one (out of two clients sampled) with a court-appointed guardian. (Client #2) The findings include: During the October 11, 2007 entrance conference, at approximately 11:20 AM, the House Manager indicated that Client #2 had a court-appointed guardian. Moments later, he presented the client's Individual Support Plan, dated April 5, 2007, in which the guardian "for medical purposes only" was documented. On October 12, 2007, at 2:01 PM, review of the

client's medical chart revealed a court document that documented the appointment of the medical

1. On October 11, 2007, at 8:21 AM, review of incident reports revealed that Client #2 was taken to an emergency room on May 31, 2007, after he sustained an injury to his forehead. Further

guardian, effective July 19, 2001.

PRINTED: 10/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 **FATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **ND PLAN OF CORRECTION** IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) W 148 Continued From page 15 W 148 review of the incident report failed to show evidence that the medical quardian had been informed. 2. On October 12, 2007, at approximately 1:15 PM, interview with the Acting Qualified Mental Retardation Professional indicated that the facility's policies stated that notification of clients' families and quardians would follow major incidents, such as emergency room visits, and this would be documented on the incident report. Notification of such incidents should be documented on the incident report. She stated that she would seek written evidence that the guardian was contacted about the May 31, 2007 emergency room visit. No written evidence that the guardian was informed of the aforementioned incident was presented before the end of the survey later that evening. 3. On October 15, 2007, at 2:20 PM, Client #2's medical guardian was interviewed by telephone. The guardian indicated that he had not been notified of any unusual incidents during the past 12 months. 4. Cross-refer to W124. The October 15, 2007 telephone interview also revealed that the medical guardian had not been informed of changes in the client's medical condition and/or medical consultations during the past 12 months. The Client #2's record, however, reflected (a) an ultrasound procedure of the abdomen was

performed on October 5, 2006; (b) upper GI tests

incidents of vomiting in June 2007; (d) an August 21, 2007 evaluation by a GI specialist; and (e) an upper GI series examination was performed on September 20, 2007 in a hospital radiology clinic

were performed on October 24, 2006; (c)

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| W 148 | (results indicated a evidenced). This is a repeat de | age 16 Inother hiatal hernia was ficiency. See Federal dated December 29, 2006. | W | 148 | | | |
| W 149 | 483.420(d)(1) STA CLIENTS The facility must dipolicies and proces | FF TREATMENT OF | W | 149 | W149 1. and 2.a. and b. Symbral Incident Report Form has been revinclude, documentation of notificating CEO. The CEO and Incident Mana Coordinator will be provided a copy incident report within 24 hours or no business day for review. The house | sed to on of the gement y of the ext | 11/30/07 |
| | Surveyor: 17815 Based on interview facility failed to est policies that ensure | | | | Manager and QMRP have been not forwarding a copy of the incident r and investigation within five (5) bus days. QMRP will verbal inform Sta agency and CEO and ensure same i documented on incident report. QA Incident Management Coordinator monitor quarterly to ensure compliant. | tified of eport siness te s A and will | |
| | 1. Although both to Incident Managem October 11, 2007, respectively) that a unknown origin, we their administrator, documentation earnoments before the evidence that their notified. Review of Management policing revealed that they should document so interview with the Management Cook | the Acting QMRP and the ent Coordinator stated on (at 3:49 PM and 4:18 PM, all incidents, including injuries of ere reported immediately to review of incident-related dier that day and then just his discussion failed to show administrator was being f the agency's Incident ies earlier, at 3:21 PM, did not specify how facility staff said notification. Further Acting QMRP and the Incident reliator confirmed that there it policy proscribing how the | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 **CENTERS FOR MEDICARE & MEDICAID SERVICES** FORM APPROVED OMB NO. 0938-0391 **FATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **ND PLAN OF CORRECTION** (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAI WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 149 Continued From page 17 W 149 W149.3 OMRP will ensure that notification of their administrator should be 11/30/07 significant incidents and injuries of documented. unknown origin are reported to the State 2. Although the Acting QMRP and Incident Agency, The Administration and Incident Management Coordinator stated that all Coordination immediately or within emergency room visits and/or incidents that twenty-four (24) hours . QMRP will present a significant risk to the clients' safety or forward information on State notification welfare were to be reported to the State agency. to the Administration and Incident in accordance with District law (22 DCMR, Coordinator. Incident Coordinator and Chapter 35, Section 3519.10), review of incident QA will monitor quarterly to ensure reports and corresponding documentation failed compliance. to show evidence that the following incidents were reported to the State agency: a. on May 31, 2007, Client #2 was taken to a hospital emergency room after sustaining a laceration to his forehead. b. on February 22, 2007, Client #1 was transported from his day program to a hospital emergency room via ambulance after experiencing lethargy. 3. Cross-refer to W153. The facility failed to consistently report significant incidents, including injuries of unknown origin, to the State agency and on a timely basis. For example, Client #1's emergency room visit on February 22, 2007 due to lethargy, and Client #2's emergency room visit on May 31, 2007 after sustaining a laceration to his forehead were not reported. 4. Cross-refer to W154. The facility failed to W149.4 Cross refer to W154, and promptly investigate Client #2's injury, after staff 11/30/07

had been implemented.

presented contradictory information, to determine whether its policies prohibiting abuse and neglect

5. Cross-refer to W156. The facility failed to

adopted

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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| W 149 | Continued From particles consistently report investigations within example, Client #2's investigation report there was no docume administrator had be to issuance of the reference of the referen | the results of all incident in 5 working days. For is May 31, 2007 incident it was dated June 21, 2007 and mented evidence that the been notified of the results prior report. If to establish and implement ring system to ensure client contation, as evidenced by the 2007, at approximately 8:04 if were loading into a was parked outside the used a wheelchair lift to assist ack area of the van. He did elchair with any straps or closing the back door. The e driver's seat and the House front passenger seat. A started to pull away without | W 149 | DEFICIENCY) | ing seat belt ing wheel yan" on tructed to when 2 staff the task and the off have been ulty do not d QMRP he next 90 | 11/30/07 10/13/07 and ongoing |
| | wheelchair was up of which might reduce motion. However, the space (at least 2 fee | close to the lift mechanism, the amount of front/back here was significant open et) to either side of the leaving it subject to tipping | | | | |

c. When asked about the chains and straps

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) N A. BU | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | | | | |
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| SYMBRA | RÖVIDER OR SUPPLIER | | | 5 | REET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | 10/10 | <u> </u> | | | | |
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| W 149 | observed on the flo back seat and next wheelchair was pla- strap, held it in varie that he did not know acknowledged that | or of the van, underneath the to where Client #1's ced, the driver picked up a cous positions then indicated w how to secure the strap. He he had not received training theelchairs in the van, to | W | 149 | | , | | | | | |
| | Manager joined in t indicated that he ha | y the same time, the House he conversation. He too ad not received training on how wheelchairs, to ensure client | | | | · | | | | | |
| | Client #1 came into into his wheelchair. wheelchair for trave community. Client Client #1 and faster seatbelt. The seath secured; it sagged House Manager that | ctober 12, 2007), at 7:46 AM, the living room and climbed. The client used the electron to the way to his day placement in the #3 quickly walked over to the ned his peer's wheelchair pelt, however, was not fully loosely across his lap. The anked Client #3 for having Client #1 then wheeled himself to the van. | | | | | | | | | |
| W 153 | Management Care and updated Septer "potential for falls." on the following: "Fi wheelchair" and "er while in van." Over assigned to the "nu | hat Client #1's Health Plan, dated March 10, 2007 mber 4, 2007, reflected his Staff were to receive training asten seatbelt while in sure wheelchair lockdown sight of these matters was rse, staff and QMRP." FTREATMENT OF | W | 153 | W153 Cross refer to W149.3 and a | adopted | 11/30/07 | | | | |
| | The facility must en | sure that all allegations of | | | | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 **FATEMENT OF DEFICIENCIES** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **ID PLAN OF CORRECTION** IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING B. WING 09G058 10/12/2007 IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ìD PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL. PRÉFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) W 153 Continued From page 20 W 153 mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Surveyor: 17815 Based on interview and review of incident reports, the facility failed to ensure that all incidents including injuries of unknown origin were reported immediately to the administrator and other officials in accordance with District law (22 DCMR, Chapter 35, Section 3519.10), for one of the four clients residing in the facility. (Client #2) The finding include: On October 11, 2007, beginning at 8:20 AM, review of incident reports revealed that on May 31, 2007, Client #2 was taken to a hospital emergency room after sustaining a laceration to his forehead. There was no evidence that this incident was reported to the State agency as required. In addition, although the Acting QMRP stated that all incidents were reported immediately to their administrator, there was no written documentation to verify that she had been notified timely of the incident. This is a repeat deficiency. See Federal Deficiency Report dated December 29, 2006. W 154 483.420(d)(3) STAFF TREATMENT OF W 154

The facility must have evidence that all alleged

violations are thoroughly investigated.

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| W 154 | This STANDARD Surveyor: 17815 Based on record failed to docume origin were thoro The finding included Incident reports a investigation report of the incident which has a coording to the sustained an injustigation along of the incident resome of the incident resome of the incident resome of the incident which the sustained an injustigation of the incident resome of the incident resome of the incident where the incident where the substant second staff performs associated the incident where the staff in questing the staff in questing QMRP has investigation report to the incident where the client had tridresser. Although on Octating QMRP has investigation report the incident where the staff in questing the facility the number of the incident of the corresponding in review that (new made. At 4:07 Coordinator (IM) | review and interview, the facility of that all injuries of unknown ughly investigated. | | W154 Administration wi of serious reportable incideroom visits and all reports unknown origin in a document with 24 hours or next business occurrence. The charge management apreliminary survisit or injury of unknown forward it to the Administ Incident Management Coc24 hours or next business conduct an investigation of conflict of interest that preinvolvement. The Incident Coordinator will monitor completion within 5 days, report will be forwarded to Agency, DDS and the Adalso received a copy of the monitor Quarterly to ensure the conflict of the completion within 5 days. | ents, emergency of injuries of mented format iness day of the urse/ DON will mmary of the ER origin and ration and ordinator within day. QMRP will unless there is a events his or her t Management to ensure timely . Copy of the to the State dministration will he report. QA will | 11/30/07 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SYMBRAL 521 KENNEDY STREET, NE WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 154 Continued From page 22 W 154 and therefore they "could not move forward... I would have to check and see whether a report" was ever generated. The IMC was unsure of the dates the direct support staff and House Manager had left but stated that he would check on the dates. He was certain that the one staff who repeatedly said that the other staff had answered he "didn't know" how the injury had occurred

At approximately 5:30 PM the next day (October 12, 2007), an investigation report was brought to the facility. The investigation report was dated June 21, 2007 (3 weeks after the incident). The report acknowledged some discrepancies in the initial statements then included the following: "Additional information from <direct support staff> and <former House Manager> is not available as both individuals has (sic) quit their positions... Based on the information available, the injury is considered to be an accident."

remained employed at the facility through the summer. When asked about the client's injury, the IMC said he didn't "recall him actually going to the ER on that incident." The IMC acknowledged

that the incident had warranted further investigation, to determine whether agency policies to prevent abuse and neglect had been correctly implemented, just prior to the client's

Follow-up interview with the IMC revealed no evidence that the investigation had been initiated promptly.

Review of staff in-service training records on October 12, 2007 revealed no evidence that staff, including administrative staff responsible for conducting investigations, had received additional training on incident management policies and

injury.

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| | | 09G058 | B. WING | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | | | 5. | REET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | 10/1 | 2/2007 |
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| W 154 | procedures, including since the May 31, 2 documented training 2007. | ng investigation requirements, 2007 incident. The most recent g was held on January 31, | W | 154 | | | |
| W 156 | This is a repeat deficiency. See Federal Deficiency Report dated December 29, 2006 483.420(d)(4) STAFF TREATMENT OF CLIENTS | | W · | 156 | W156 Cross refer to W154 and adopted Administration will ensure that the results | | 11/15/07 and |
| | to the administrator | vestigations must be reported or designated representative in accordance with State law days of the incident. | | | of investigation are received within working days of incident. Inservice is scheduled for 11/15/2007. Staff receive annual updates and PRN r QA will monitor to ensure compliant. | te training If will refreshers. | ongoing |
| | Surveyor: 17815 Based on record rev failed to document t investigations were administrator within | view and interview, the facility that the results of all reported to the facility's 5 working days, in cility policies and federal | | The state of the s | | | |
| | The finding includes | s: | | | | | |
| | reports written to de occurred on May 31 incident reports, Clie his forehead while h direct support staff | | | | | | |
| | corresponding inves | stigation report revealed that it 2007 (3 weeks after the | | | | | |

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| | NAME OF PROVIDER OR SUPPLIER SYMBRAL | | | 521 | ET ADDRESS, CITY, STATE, ZIP CODE I KENNEDY STREET, NE ASHINGTON, DC 20011 | | |
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| W 156 | discrepancies in the included the follow from <direct (sic)="" 12,="" 20="" accident."="" acknowledged="" ad="" agency="" an="" and="" at="" available="" be="" becomes="" been="" conducting="" coordinator="" correctly="" follow-up="" further="" had="" impolient's="" incident="" including="" injury.="" interview="" invest="" investigation="" investigations.<="" is="" managers="" not="" note:="" october="" of="" on="" or="" policies="" positinformation="" procedures,="" quit="" results="" reveal="" review="" son="" staff,="" support="" td="" that="" the="" their="" this="" to="" training=""><td>ort acknowledged some be initial statements then ing: "Additional information of staff> and <former 2007="" 5="" abuse="" actor="" additional="" agency="" also="" and="" as="" at="" based="" both="" considered="" days,="" determine="" ding="" ere="" estigation="" evidence="" findings.="" for="" had="" has="" he="" house="" igations,="" in-service="" incident="" incident.="" individuals="" initiated="" injury="" investigation="" investigative="" is="" itaff="" just="" led="" management="" ministrative="" most="" neglect="" no="" notified="" oblemented,="" of="" ole,="" on="" on,="" open="" policies="" prevent="" prior="" promptly.="" received="" recent<="" records="" reported="" requirements,="" responsible="" revealed="" staff="" state="" td="" that="" the="" tions="" to="" training="" vailable="" warranted="" was="" were="" whether="" with="" within="" working=""><td></td><td>156</td><td></td><td></td><td></td></former></td></direct> | ort acknowledged some be initial statements then ing: "Additional information of staff> and <former 2007="" 5="" abuse="" actor="" additional="" agency="" also="" and="" as="" at="" based="" both="" considered="" days,="" determine="" ding="" ere="" estigation="" evidence="" findings.="" for="" had="" has="" he="" house="" igations,="" in-service="" incident="" incident.="" individuals="" initiated="" injury="" investigation="" investigative="" is="" itaff="" just="" led="" management="" ministrative="" most="" neglect="" no="" notified="" oblemented,="" of="" ole,="" on="" on,="" open="" policies="" prevent="" prior="" promptly.="" received="" recent<="" records="" reported="" requirements,="" responsible="" revealed="" staff="" state="" td="" that="" the="" tions="" to="" training="" vailable="" warranted="" was="" were="" whether="" with="" within="" working=""><td></td><td>156</td><td></td><td></td><td></td></former> | | 156 | | | |
| W 159 | documented train 2007. 483.430(a) QUAL RETARDATION | ing was held on January 31, LIFIED MENTAL PROFESSIONAL | | / 159 | | | |
| | integrated, coord | ve treatment program must be inated and monitored by a retardation professional. | | | | | |

PRINTED: 10/31/2007

| ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
|---|--|--|--------------------|---------|--|---|----------------------------|--|
| | | 09G058 | B. WIN | B. WING | | | 10/12/2007 | |
| SYMBRA | ROVIDER OR SUPPLIER | | • • • • | 53 | EET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE /ASHINGTON, DC 20011 | | 72007 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| W 159 | Surveyor: 17815 Based on observation review, the facility's Professionals (QMF monitor, integrate at treatment programs two clients in the sate The findings included During an October at approximately 5: stated that a previous July 2007. Since the hired but left after 2 was hired but he left hours. Throughout facility's Incident Mareportedly shared in Gaps in QMRP sendentified, as follows 1. Cross-refer to Wensure that Client # guardian was information and proposition and proposition and proposition and proposition of the facility of the setting that assures medical information 3. Cross-refer to Wensure that clients in setting that assures medical information 3. Cross-refer to We failed to ensure that community-based setting that assures medical information 3. Cross-refer to We failed to ensure that community-based setting that assures medical information 3. Cross-refer to We failed to ensure that community-based setting that assures medical information 3. Cross-refer to We failed to ensure that community-based setting that assures medical information 3. Cross-refer to We failed to ensure that community-based setting that assures medical information 3. | on, interview and record Qualified Mental Retardation RPs) failed to adequately nd coordinate clients' active and services, for two of the imple. (Clients #1 and #2). 10, 2007 telephone interview, 15 PM, the Acting QMRP us QMRP had left the facility in en, another QMRP had been weeks. Yet another QMRP it within approximately 24 this period, she and the anagement Coordinator in covering QMRP duties. Vices, however, were s: 1124. The QMRP failed to 2's court-appointed medical med of the client's medic | W 1 | | W159.1 - 159.10 A Full-time (was hired on 10/16/2007. QMRP) initiated reviewing of all Active Tro Goals in conjunction with medical delivery. QMRP has identified are program implementation, documer programmatic plans for revision. It are being placed in the individuals correcting identified state deficience as QMRP revisions. Data sheets are vised and updated and staff insertraining will follow revisions. DON QMRP will review program implet to ensure compliance. QMRP will that recommendations provided by consultants/ clinicians which are act the ISP are implemented after the been trained. QMRP/ QA will morensure compliance. Cross refer to W124, W130, W136, W247, W143, W148, W436, W193.3, W460, W255 and adopted | has eatment service as of ntation and nitial notes records ties as well te being vice I and mentation ensure lapted by staff has nitor to W159.7, | 12/15/07 | |

PRINTED: 10/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 JAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION PRÉFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) W 159 Continued From page 26 W 159 4. Cross-refer to W143. The QMRP failed to establish and implement an effective system for promoting the participation of family members and/or legal guardians in the active treatment process, and documenting contacts with all concerned parties in the clients' records. 5. Cross-refer to W148. The OMRP failed to establish and implement an effective system for informing clients' involved family members and/or legal quardians of significant incidents. 6. Cross-refer to W436. The QMRP failed to ensure that clients were provided with and taught to use their adaptive equipment, such as coated spoons, protective elbow and knee pads, wrist and/or elbow splints and shoulder exercise pulleys, and to ensure that staff received corresponding training. 7. The QMRP failed to follow-up on a recommended range of motion exercise program for Client #1, as follows: Client #1's physical therapy assessment, dated February 27, 2007, included a recommendation that he engage in an exercise program "to improve range of motion in his hands... will tolerate range of motion exercises to his hands 10 of 10 trials, days per week for 12 consecutive months." There was no corresponding program in the client's IPP book. On October 12, 2007, at 7:28 PM, interview with staff (coupled with further review of the client's IPP) revealed that staff had not implemented range of motion exercises of his hands. They stated that they feared he would be

injured; "we can't... has contractures... the bones have locked." Staff interview also revealed that

they had not implemented Client #2's

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES ITATEMENT OF DEFICIENCIES

| ND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTIPL A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
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| · | | 09G058 | B. WING | | 40% | 4040000 | |
| SYMBRA | ROVIDER OR SUPPLIEF | | STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20011 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD RE | (X5) COMPLETION DATE | |
| | recommended sh A pulley had been however, staff sai and there was no sheet in the client Acting QMRP and training records revidence that staff physical therapist previous 12 montil 8. Cross-refer to ensure that staff hand training to ensure that staff hand training program. QMRP had met when impler were not writing doquestions they asl program as writter therapist. Staff hat they asked the document the clienthe program. The indicated that they either the speech/QMRP on how to incommunication proceeding the program of the communication procedured training of communication procedured training of the communication procedured training t | oulder exercise using a pulley. I delivered in February 2007; Id thay had not been trainined corresponding data collection is program book. Interview with a review of staff in-service evealed no documented if had received training from the or the QMRP during the ins. W194.3. The QMRP failed to ad the necessary information sure proper implementation and Client #1's communication. There was no evidence that the lith staff to decide upon the 10 restions they were to ask the menting the program. Staff own the which and/or how is the speech/ language did used a + sign to document in eclient a question but did not int's response, as indicated in House Manager and staff had not received training from language therapist or the implement the clients' ograms. In-service training to evidence that staff had in how to implement the clients' | W 159 | | | | |

| ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | | | (X3) DATE SUR COMPLETE | | |
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| AME OF PI | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20011 | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE AC | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| W 159 | their programs had a QMRP since the their annual ISP m and March 6, 2007 to the survey). | ailed to show evidence that d been reviewed periodically by y were established following leetings held March 21, 2007 7, respectively (7 months prior | • | 159 | | | | |
| W 194 | Staff must be able techniques necess program plans for responsible. | STAFF TRAINING PROGRAM able to demonstrate the skills and ecessary to implement the individual is for each client for whom they are ARD is not met as evidenced by: | | 194 | W194.1.a. Staff have been inserviced on individual #1 Adaptive equipment (coated spoon) on 10/24/2007. QMRP will ensure that all staff are inserviced on individuals' adaptive equipment. House Manger and QMRP will monitor to ensure proper program implementation. House Manager and QMRP will conduct random proficiency audits over the next 90 days and ongoing | | 10/24/07 and ongoing | |
| | Based on observative review of staff in-staff failed the implementation | • | | | there after. QA will monitor quantity Cross refer to W436.1 and adopted | terly. | | |
| | 1. The facility faile | ed to ensure staff displayed ilizing Client #1's adaptive | | | | | | |
| | at dinner on Octo the following mor (child-sized) met plastic handle. F October 12, 200 prescribed a plas meals. Upon ind a coated spoon | W436.1. During observations ober 10, 2007 and at breakfast ming, Client #1 ate with a small al spoon with a blue and green Review of the client's record on 7 revealed that he was stic-coated spoon for use at all juiry at 7:18 PM, staff presented (pink) which had not been used ng the survey. Review of staff | | | | | | |

| STATEMENT OF DEFICIENCIES | | (V4) PROMPERIOUS ASSESSMENT | | | | OMB NO. 0938-0391 | |
|---------------------------|--|--|---------------------|-------------------------------|--|-------------------------------|----------------------------|
| AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | MULTIPLE CONSTRUCTION UILDING | | (X3) DATE SURVEY COMPLETED | |
| | | 09G058 | B. WING | | | 10/12/2007 | |
| NAME OF F | ROVIDER OR SUPPLIER | | | ет | DEET ADDRESS AND AND THE | 1 10/1 | 212007 |
| SYMBRA | AL. | | | 5 | REET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE | | |
| | | · | | V | VASHINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | ID PREFIX TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | DULD BE | (X5) COMPLETION DATE |
| W 194 | in-service training reservice training reservice training reservice training reservice that the staff observed in the use of his coate recently-hired House October 11, 2007, previously unaware adaptive spoon. b. Cross-refer to Vobserved in the horion 10, 2007 and again day program observations that a the home. At no tirusing elbow of knew on all fours.' Howereview of Client #1's revealed: "elbow ar prescribed to prevealed: "elbow a | records revealed no evidence wed working with the client on 2007 had received training on ed teaspoon. In addition, the se Manager indicated on at 10:52 AM that he was of the client's need for an at 10:52 AM that he was of the client's need for an at 10:52 AM that he was no on the evening of October the next morning, followed by vations and then additional fternoon (October 11, 2007) in the was the client observed a pads while he moved about ever, on October 12, 2007, at ISP, dated March 21, 2007, at knee guards were not injury to these areas of his is elbows and knees to cors <client's name=""> prefers are indoors." At 5:10 PM, the red staff assistance with a 7:08 PM, two direct support rout the pads. They incorrectly a should be worn when he was the client on the work ware that he should wear them Review of staff in-service ealed no evidence that the ing with the client on October</client's> | W | 194 | · · · · · · · · · · · · · · · · · · · | vice will entation | 12/15/07 |
| | of his protective elb c. Cross-refer to W review of in-service staff had not receive | d received training on the use | | , | | , | |

| | | & MEDICAID SERVICES | | | OMB NO. | 0938-0391 | |
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| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | LTIPLE CONSTRUCTION | | (X3) DATE SURVEY | |
| | CORRECTION | IDENTIFICATION NUMBER: | A. BUILE | DING | COMPLE | TED | |
| | | 09G058 | B. WING |) <u></u> | 40/4 | 0/0007 | |
| NAME OF P | ROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | | STREET ADDRESS, CITY, STATE, ZIP C | | 2/2007 | |
| SYMBRA | .1 | | | 521 KENNEDY STREET, NE | ODE | | |
| OTMER | | | | WASHINGTON, DC 20011 | • | | |
| (X4) ID | SUMMARY STA | TEMENT OF DEFICIENCIES | ID | PROVIDER'S PLAN OF CO | DRRECTION | (X5) | |
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| W 194 | Continued From pa | ge 30 | 104.45 | | | | |
| - 7 7 2 1 | | aff also confirmed that the | W 19 | W 194.2 QIVIRP and House | | 12/15/07 | |
| | item had been rece | ived in late May 2007, as per | | implement staff inservice trai | | ļ | |
| | the date marked or | the shipping label. | | by PT. QMRP will monitor t implementation and document | | | |
| | d. Cross-refer to W | /159.7. On October 12, 2007, | | | | | |
| | interviews with dire | ct support staff and the Acting | | • | | | |
| · | QMRP as well as a | review of staff in-service | | | | | |
| | training records rev | ealed no documented | , | | | İ | |
| | physical therapiet (| had received training from the | | | | | |
| | months It should be | PT) during the previous 12 be noted that there was no | | | | | |
| | evidence that the P | T had been reviewing clients' | | | | - | |
| | programs, or was o | therwise involved in the active | | | | Ī | |
| ļ | treatment process : | since the client's ISP meeting | | | | Ì | |
| | held on March 21, 2 | 2007. | • | | | | |
| • | 2. Cross-refer to W | /436.4. The facility failed to | | | | | |
| | ensure staff display | ed competency in | | | | | |
| | implementing Clien | t #2's shoulder exercise | | | | | |
| | program using a pu | illey. On October 12, 2007, | | | | | |
| | dated February 27 | s annual PT assessment, | • | | | | |
| } | physical therapiet h | 2007, revealed that the ad recommended a shoulder | | | | | |
| | exercise program in | nvolving the use of a pulley. | | | | | |
| · | Observations and s | taff interviews had not | | | | | |
| | previously indicated | the use of a pulley for the | | | | . , | |
| | client's exercise pro | gram. At 7:35 PM, two direct | | · · | | | |
| | .support staff and th | e recently-hired House | | · | | | |
| į | Manager presented | a shipping box that contained | | | | | |
| : | interviews and revis | exercise pulley. Further | | • | | İ | |
| , | had been delivered | ew revealed that (a) the pulley in February 2007, (b) to date, | | | | | |
| | the client had not us | sed the pulley, (c) staff had not | | | | | |
| | been trained on the | proper use, and (d) | | | | | |
| | "someone" (staff no | ot sure who) had not showed | | | | | |
| | up at a previous sta | off meeting for in-service | | | | | |
| | training (date not sp | pecified) and no additional | | | | | |
| | in-service training h | ad been provided to date. | | | | | |

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| • | | 09G058 | B. WING | | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | 5 | EET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | 10/1: | 2/2007 | |
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| W 194 | 3. The facility failed necessary informated proper implemental Client #1's communifollows: Client #1's IPP inclient were to ask the client was the | d to ensure that staff had the sion and training to ensure tion and documentation of nication training program, as uded a program whereby staff ent wh and/or how questions. If were to decide on 10 whoms they felt were appropriate, but the client's daily routines age therapist had suggested als and leisure times). The 10 be written onto the program The program further indicated staff were to select 1 question write the question on the data d then use the same question | W 1 | | W194.3 a - g QMRP and House will proper implement and docume the program developed by the Spe Therapist. The staff will receive in training from the QMRP. Speech will review individual's progress. (monitor to ensure proper implement and documentation. | entation of ech service Therapist QMRP will | 12/15/07 | |
| | that was designate had been left blank b. Review of the d September 2007 rewritten down the w c. Review of the d September 2007 a collection. Docum consisted of all l's According to the lessheet, an I represe The September sh legend said that + d. On October 12, | d for writing the 10 questions | | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE SYMBRAL 521 KENNEDY STREET, NE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 194 Continued From page 32 W 194 indicated that he was unfamiliar with the program. e. Two direct support staff who worked the evening shift with Client #1 were interviewed upon their return to the facility (from grocery shopping). The August and September 2007 data sheets showed their initials as having implemented the program on certain days. At 7:13 PM, they both confirmed that they routinely asked the client wh and/or how questions. However, they both stated that they marked a + to reflect that they had asked the client a question. They acknowledged that the + sign did not represent the client's response to the program. (Note: They also stated the client answers questions when asked, and did not need a verbal prompt to give an answer.) f. Further interview revealed that the direct support staff did not know that they should write down the question(s) that they asked him or that they should ask the same question(s) for 30 days.

W 247

properly document the client's response. 483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and

g. Staff interview and review of in-service training records failed to show evidence that the QMRP and/or the speech/ language therapist had trained them in how to implement the program and

This STANDARD is not met as evidenced by: Surveyor: 17815

Based on observation, staff interview, and record review, the facility failed to ensure that each client was provided opportunities for choice,

Event ID: AEOI11

W 247

self-management.

| | | | | | | OIVID (NO. | <u> </u> |
|--------------------------|---|---|-------------------|-----|--|---|----------------------------|
| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BU | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
| | | 09G058 | B. WING | | | 10/12/2007 | |
| NAME OF P | ROVIDER OR SUPPLIER | | | STR | EET ADDRESS, CITY, STATE, ZIP CODE | 10/1/ | |
| SYMBRA | \L | , | | 5 | 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| W 247 | The findings included. Cross-refer to Wensure Client #1 was attend live theatre (was an assessed pinterest, as per his of his IPP revealed for him to "participarecreational activities further review of the failed to outline pot choice. Review of recreational activities evidence that he has the previous 12 mo Client #2's docume revealed no eviden social or communities assessed interests. On October 10, administration was PM. At 6:12 PM, the Client #1's medicate in apple sauce and nurse held the spoot her hands, she spoot mouth and then as ahhh. The client, was water in his right has from the cup without 12, 2007, at approximation and the process. | ght skills for for two of the two clients in the for two of the two clients in the for two of the two clients in the for two of the two clients in the for two days. Also, The facility failed to as afforded the opportunity to musicals and plays), which referred recreational/ social March 21, 2007 ISP. Review a service objective in his IPP at the in a minimum of 4 as per month." However, as program revealed that it ential recreational activities of the client's community/ as record revealed no ad been to a live theatre during in the client's community/ as record revealed no ad been to a live theatre during in the client's community/ activities of his choice or 2007, the evening medication observed, beginning at 5:50 are medication nurse placed ion (Depakote, 500 mg tablet) presented it to him. The on and the medication cup in oned the medication into his ked him to swallow and say who had been holding a cup of and independently, then drank at any prompting. On October simately 2:30 PM, review of the | W | 247 | W247.1 Cross refer to W136 and W247.2 Nurse has been inservice Individual #1 Medication Administ Assessment and the required protein implementation to ensure the individual participation in self medication act Direct Care Staff, House manager QMRP will monitor to ensure con Charge Nurse /DON will conduct audits over the next 90 day to ensure compliance and ongoing there after the participation of the participation in self medication act Direct Care Staff, House manager QMRP will monitor to ensure con Charge Nurse /DON will conduct audits over the next 90 day to ensure compliance and ongoing there after the participation in self medication act Direct Care Staff, House manager QMRP will monitor to ensure con Charge Nurse /DON will conduct audits over the next 90 day to ensure compliance and ongoing there after the participation in self medication act Direct Care Staff, House manager QMRP will monitor to ensure con Charge Nurse /DON will conduct audits over the next 90 day to ensure compliance and ongoing there after the participation in self medication act Direct Care Staff, House manager QMRP will monitor to ensure con Charge Nurse /DON will conduct audits over the next 90 day to ensure compliance and ongoing there after the participation in self-medication act Direct Care Staff, House manager QMRP will monitor to ensure con Charge Nurse /DON will conduct audits over the next 90 day to ensure compliance and ongoing there after the participation in the part | ce on tration ocol for vidual's ivities. and apliance. random ure | 11/30/07 |
| | | tion assessment, dated March the following: he "will be | | | | • | |

PRINTED: 10/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES <u>OMB NO. 0938-0391</u> TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **SYMBRAL** 521 KENNEDY STREET, NE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION D (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRFFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 247 Continued From page 34 W 247 encouraged to participate with medication... will take medication cup from nurse... will swallow medications with fluid with verbal prompts..." The written self-medication procedures as outlined did not reflect the client's current medication administration process (with apple sauce) or skills. Although the client was observed using a spoon to eat food independently during meals, the medication nurse did not encourage him to use the spoon with the apple sauce, for self-management. W 255 483,440(f)(1)(i) PROGRAM MONITORING & W255 1, and 2. Cross refer to W159 and 12/15/07 CHANGE adopted. A Full-time OMRP was hired on The individual program plan must be reviewed at 10/16/2007. OMRP has initiated review of least by the qualified mental retardation professional and revised as necessary, including, all Active Treatment Goals in conjunction with medical service delivery. QMRP has but not limited to situations in which the client has successfully completed an objective or objectives identified area of program implementation. identified in the individual program plan. documentation and programmatic plans which are being revised. Initial notes are being placed in the individuals records This STANDARD is not met as evidenced by: outlining the corrective action and correcting Surveyor: 17815 the identified state deficiencies. QMRP will Based on observations, staff interviews and complete revisions on an as needed basis, record review, the Acting Qualified Mental and complete quarterly report. OA will Retardation Professional (QMRP) failed to review monitor to ensure compliance. and revise the Individual Program Plan (IPP) once the client successfully completed an objective identified in the IPP, for two of the two clients in the sample. (Clients #1 and #2)

The findings include:

1. The facility's Acting QMRP failed to revise Client #1's program objectives. Data collection sheets indicated that Client #1 had been "independent" in responding to his program to "learn to tell time correctly" since June 20, 2007.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **521 KENNEDY STREET, NE** SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 255 Continued From page 35 W 255 There were no revisions made to the program since he achieved at the stated criterion level. Interviews with the direct support staff and the Acting QMRP, and review of the client's record failed to show evidence that this or other program goals and objectives had been periodically reviewed by a QMRP. 2. Client #2's IPP indicated that the client would receive hand over hand support while brushing his teeth. Data collection sheets since April 2007 showed that he was performing at 100% with hand over hand assistance. The program had not, however, been revised to move the client to the next level towards independence. Interviews with the direct support staff and the Acting QMRP, and review of the client's record failed to show evidence that this or other program goals and objectives had been periodically reviewed by a QMRP. W 331 483.460(c) NURSING SERVICES W 331 W331.1, 2 and 4 DON has inserviced 11/30/07 medication nurse on the "effective and The facility must provide clients with nursing administration of medication" on 10/16/2007 services in accordance with their needs. ongoing and conducted an observation. The Charge Nurse and the DON will conduct random observation to ensure effective medication This STANDARD is not met as evidenced by: Surveyor: 17815 delivery Based on interview and record review, the facility Cross refer to W369 and adopted. failed to provide nursing services in accordance with the client's needs, for two of the two clients in A schedule of Nursing Quarterly reviews the sample. (Clients #1 and #2) have been developed. The Consultant RN.

The finding includes:

1. On October 12, 2007, review of Client #2's

Assessment dated March 1, 2007. The annual

assessment documented 3 hospital emergency

medical records revealed an annual Nursing

individuals records.

the charge nurse and RN have reviewed the

schedule for effective implementation. The consultant RN will forward to the DON

notice of completion of the quarterlies. The

DON will conduct scheduled follow-up to

ensure that the documentation is within the

| ND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE S COMPL | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI DEFICIENCY | | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| W 331 | including surgery RN then documer 30, 2007, and had Management Car However, Client # evidence that the examination and health condition s [Note: There was RN had reviewed (only) on Septembrand and the Nursing revealed impression that the comprehensive quantity of the surgery | the previous 12 months, to repair a hiatal hernia. The need a quarterly review on June dupdated the Health e Plan (HMCP) accordingly. 2's record failed to show RN had conducted a physical review of the client's overall ince the June 2007 quarterly. documentation showing that the his gastro-intestinal issues per 29, 2007. However, see 3 below.] Subsequent Acting QMRP/ Director of that she was under the e RN had conducted a parterly review. | W 331 | | | |
| | at 6:53 PM and 10 observation of Clie October 12, 2007, October 12, 2007, 9:25 AM, revealed ensured that the helevated, in accompanient #2's HMCP updated by the co 2007. However, in that it did not refle specialist's Augus keep the head of 0.4. Cross-refer to medication pass of that the medication effective means to | s on October 10 and 11, 2007, 2:52 AM, respectively, ent #2's bed and bedroom on and review of his chart on beginning at approximately no evidence that facility nurses read of Client #2's bed was kept dance with the gastro-intestinal t 21, 2007 recommendation. had been reviewed and insulting RN on September 29, eview of the HMCP revealed of the gastro-intestinal t 21, 2007 recommendation to Client #2's bed elevated. W369. Observation of the in October 10, 2007 revealed in nurse did not implement administer Client #1's d Client #2's baby oil drops in | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/31/2007 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE **SYMBRAL** WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) W 331 Continued From page 37 W 331 both ears. Interview with the medication nurse revealed that she had not been observed by supervisors administering these medications. The LPN Coordinator for the facility was away on leave during the survey. Interview with the Acting QMRP/ Director of Nursing revealed that she had not observed a medication pass during the previous 12 months. Review of the in-service training records revealed no evidence that nursing staff had received training on the effective administration of nasal sprays, ear drops or other prescribed medications. W 356 483.460(g)(2) COMPREHENSIVE DENTAL W 356 Return Appointment to the dentist will be 12/15/07 TREATMENT completed by 12/15/2007. In future any dental that is delayed more that 30 day The facility must ensure comprehensive dental because of pre-authorization, the DON, treatment services that include dental care the Administration and DDS Case-manger needed for relief of pain and infections, will be notice and a record placed in restoration of teeth, and maintenance of dental individual. Nursing will continue to health. document efforts at least monthly until barrier is resolved or alternative This STANDARD is not met as evidenced by: intervention i.e. another vendor. DON will Surveyor: 17815 monitor to ensure compliance. Based on interview and record review, the facility failed to ensure that clients received dental services in a timely manner, for one of the two clients in the sample. (Client #1) The finding includes:

On October 12, 2007, at 4:13 PM, review of Client #1's dental record revealed that he received a dental assessment on October 4, 2006. On October 4, 2006, the dentist documented "heavy calculus deposits" and recommended "patient needs scaling... will submit pre-authorization to Medicaid..." The client's record documented a return visit to the dentist on June 6, 2007, at

| | | I AND HUMAN SERVICES & MEDICAID SERVICES | | | | | : 10/31/2007 APPROVED | |
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| NAME OF F | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20011 | | | | | |
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| W 356 | which time the denti deposits" and recor scaling will submi Medicaid" Further that day revealed no received the recomn after it was first pre House Manager revealed not had the scalano return appointment 483.460(k)(2) DRU | ist found "moderate calculus mmended "patient needs to pre-authorization to preview of the client's record to evidence that the client mended scaling, one year scribed. Interview with the yealed that to date, the client aling performed and there was ent scheduled. G ADMINISTRATION g administration must assure | W 3 | | V369 Cross refer to W331. | .1 and adopted. | 11/30/07 | |
| | Surveyor: 17815 Based on observati review, the facility famedications were a two of the four clien (Clients #1 and #2) The findings include | dministered as prescribed, for its residing in the facility. | | | | | | |
| | observed on October PM. The following 1. At 6:15 PM, the sprays of Nasonex | ation administration pass was er 10, 2007, beginning at 5:50 errors were observed: medication nurse squeezed 2 Nasal spray into Client #1's s. The client, however, did not | | | · | | | |

take in a breath at the appropriate moments when the nurse squeezed the nasal spray bottle. The nurse did not offer the client any instructions during this process. The nurse was not observed using effective means to ensure that Client #1

| TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | | <u>,-</u> | 52 | EET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE /ASHINGTON, DC 20011 | 10/12 | 2/2007 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | ıx | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| W 369 | accordance with th 2. At 6:25 PM, the drops of baby oil in client's head, howe | age 39 ribed nasal spray in e physician's orders. medication nurse applied 5 to Client #2's right ear. The ever, was only slightly tilted s soon as the oil entered his | w: | 369 | | | | |
| W 436 | ear, he turned his his ear (and down his ear (and down his ear (and down his ear) from his ear before cotton in his ear. To client any instruction nurse was not obseensure that Client his baby oil in accordance. | head and the oil drained out of his neck) before the nurse put he ear. She repeated the the left ear and again, the had quickly and the oil drained he she was able to place the he nurse did not offer the hors during this process. The herved using effective means to #2 received his prescribed noce with the physician's orders. CE AND EQUIPMENT | W 4 | 136 | | | | |
| | and teach clients to choices about the thearing and other cand other devices i | rnish, maintain in good repair, o use and to make informed use of dentures, eyeglasses, communications aids, braces, identified by the client. | | | | | | |
| | Surveyor: 17815 Based on observat review, the facility f were provided with adaptive equipmen protective elbow ar elbow splints and s | is not met as evidenced by: ion, staff interview and record failed to ensure that clients and taught to use their it, such as coated spoons, ind knee pads, wrist and/or shoulder exercise pulleys, for its in the sample. (Clients #1 | | The state of the s | | , | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| W 436 | coated spoon was meals, as follows: On October 10, 20 observed eating was spoon with a blue client was observed breakfast the next 2007, at 10:52 AM Manager stated the client used the little to look through the October 12, 2007 #1's Individual Su 21, 2007, reveale coated spoon. At staff was asked a She presented and stated that the presented to the | | W 436 | W436.1,2,3, and 4. PT cond on 10/24/2007. QMRP will nensure that individual and star on the use on adaptive equipitimely manner when the equipitimely problems in source, se training of individual. QMRF efforts to resolve issue/s and administration on at least mo Consultant Clinician will be a delay of the program implem QA will receive a copy of the ISP is developed and will rever by the 30th day to ensure IPI been commenced without descriptions. | nonitor to ff are inserviced ment within a pment is y curing and will document update the nthly and PRN notified of the hentation. IPP after the view in the home P goals have | | |
| | Facility staff di use elbow and kr to prevent injuries | id not encourage Client #1 to nee guards that were prescribed s, as follows: | | | | | |
| | observed navigal dining room. De abnormalities, he about the home. hands on the floobackwards, and | 2007, at 6:09 PM, Client #1 was ting from his bedroom to the spite his significant physical e was independent in moving. He propelled himself with his or, his legs were pointed his left knee dragged across the used the same means of moving | | | | | |

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| SYMBRA | ROVIDER OR SUPPLIER | | | 521 | ET ADDRESS, CITY, STATE, ZIP CODE KENNEDY STREET, NE ASHINGTON, DC 20011 | | |
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| W 436 | himself when he redinner that evening observed moving a the client used a min the community, i | age 41 sturned to his bedroom after and at other times he was about his home. By contrast, notorized wheelchair while out including his day program. | W | 136 | | | |
| | #1's ISP, dated Ma and knee guards w injury to these area elbows and knees <client's name=""> pro indoors." He had r protective elbow or the survey. At 5:10</client's> | rch 21, 2007, revealed: "elbow vere prescribed to prevent as of his body as he uses his to mobilize when indoors efers self-ambulation when not been observed wearing knee pads previously during D PM, the client was pedroom. His elbow and knee | | | | | |
| | pads were stored of He indicated that he putting them on. We them or not, he offer 7:08 PM, two direct about the pads. The be worn when he le morning. He report and removed them every afternoon. We them while in the he not necessary since | penly near the bedroom door. e required staff assistance with when asked if he liked wearing ered an unclear response. At it support staff were asked ney stated that the pads should eft for day program in the tedly did not like wearing them promptly upon return home when asked if he should wear ome, the staff replied that was e he was in bed most of the t use them when coming to the | | | | | |
| | clients were trained prescribed wrist sp not used the wrist s following: | d to ensure that staff and d on the use of Client #1's lints, therefore, the client had splints, as evidenced by the | | | | | |
| | On October 12, 200 | 07, at 5:35 PM, review of Client | • | | | | |

PRINTED: 10/31/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 42 W 436 W 436 February 27, 2007, revealed the following recommendation: "<client's name> will benefit from rest (sic) splints." The client had not been observed using wrist splints during the survey. At 7:28 PM, two direct support staff were asked about the wrist splints. They went to the client's bedroom and retrieved his elbow and knee pads, saving that he did not like to wear them. At 7:35 PM, the same two staff and the recently-hired House Manager pointed to 2 shipping cartons that were on top of some shelves in the dining room. One of the boxes contained Client #1's "Elbow Comfv Splint." Further interviews and review revealed that (a) the shipping label indicated that the Elbow Comfy Splint had been delivered May 23, 2007, (b) to date, the client had not used the splint, (c) staff had not been trained on the proper use, (d) staff were unsure about the difference/ distinction between elbow splints and wrist splints. (e) a specialist had not showed up at a previously-scheduled staff in-service training (date not specified) and no additional in-service training had been provided. It should be noted that there was no evidence that the physical therapist had returned to the facility since the ISP meeting and/or reviewed the use of Client #1's adaptive equipment. 4. The facility failed to ensure that staff and clients were trained on the use of Client #2's shoulder exercise pulley; therefore, the client had

following:

not started the recommended exercise program in accordance with his ISP, as evidenced by the

On October 12, 2007, at approximately 6:06 PM, review of Client #2's annual PT assessment, dated February 27, 2007, revealed that the

| | NT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| W 436 | physical therapist exercise program Observations and previously indicate client's exercise psupport staff and Manager pointed on top of some shof the boxes contexercise pulley. Frevealed that (a) the pulley had been (b) to date, the client's of the boxes contexercise pulley. Frevealed that (a) the pulley had been (b) to date, the client staff had not been (d) "someone" (staff had not been do not be showed up at a prin-service training additional in-service training additional in-service the physical theral | had recommended a shoulder involving the use of a pulley. I staff interviews had not sed the use of a pulley for the program. At 7:35 PM, two direct the recently-hired House to 2 shipping cartons that were nelves in the dining room. One ained Client #2's shoulder further interviews and review the shipping label indicated that the delivered in February 2007, ient had not used the pulley, (c) in trained on the proper use, and aff not sure who) had not revious staff meeting for a (date not specified) and no ce training had been provided. | W | 436 | | | |
| | It should be further interviews with the 2007, at 8:20 PM 11:31 PM, revealed unsure of the date appeared for the thought the "specified ordered the anot confirm, (3) disconsulting physic that the equipment since the Februar whether the physic | eting and/or reviewed the use of see programs. er noted that telephone er Acting QMRP on October 12, and on October 15, 2007, at ed the following: (1) she was er the "specialist" had not staff in-service training, (2) she dialist" may have been a seem the company from which they endaptive equipment, but could id not know whether the all therapist had been informed and the delivered after/ry and March ISPs, and/or (4) ical therapist had been the other "specialist's" in-service. | | | | | |

| | F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A BUI | | PLE CONSTRUCTION G | (X3) DATE SU COMPLE | |
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| W 436 W 460 | evidence that atte reschedule the in- #1 and #2's needs | ad fallen through. There was no mpts had been made to service training to meet Clients | | 436 | | 11 0.00 | 10/26/07 |
| VV 400 | SERVICES Each client must i | receive a nourishing, t including modified and | | 460 | W460.1.a,b,c and d, W460.2.a a have been inserviced on meal time individual diets and the menus on 10/26/2007. The House Manager QMRP will monitor to ensure cor Staff will be inserviced annual, Pl within his or her initial 30 days of | e protocol, and mpliance. RN and | 10/26/07 and ongoing |
| | This STANDARD is not met as evidenced by Surveyor: 17815 Based on observation, interview and record review, the facility failed to ensure nutritional intake in accordance with prescribed dietary orders, for three of the four clients residing in facility. (Clients #1, #2 and #4) | | | | employment. QMRP will monito compliance. | r to ensure | |
| | | de: ot receive Instant Breakfast in ohysician's orders, as follows: | | | | | |
| | a. The client was October 10, 2007 was alone in his thad finished dinned bedroom). Obsermorning, October observed leaving came to the dining remained within witheir day program. The client was no during either of the october of the | observed in the facility on beginning at 5:00 PM (when he bedroom) until 6:58 PM (after he er and retreated to his rvations resumed the next 11, 2007. Client #1 was his bedroom at 7:05 AM (he groom for breakfast) and riew until he and his peers left for its, at approximately 8:09 AM, of being offered Instant Breakfast ite observation periods. | | , | | | |
| | b. While direct so | upport staff talked about Client | | | | | |

| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|---|-------------------|-----|---|-------------------------------|----------------------------|
| | 09G058 | | B. WI | ۱G | | 10/12 | 2/2007 |
| NAME OF P | ROVIDER OR SUPPLIEF | | • | 52 | EET ADDRESS, CITY, STATE, ZIP CODE 11 KENNEDY STREET, NE ASHINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| W 460 | #2's Boost nutritic said about Client Breakfast. Later Manager indicate Conference, at 1 was the only spe prescribed. There order for Instant 2007. c. The order for was identified on record verificatio of Client #1's phy 2007, revealed the Instant Breakfas supplement. The immediately interesting the said of the said | pinal supplement, nothing was #1's orders for Instant that morning, the House d during the Entrance 0:23 AM, that Client #2's Boost cialized nutritional/ dietary order e was no mention of Client #1's Breakfast on October 10 or 11, Instant Breakfast, twice daily, October 12, 2007, during the process. At 10:07 AM, review resician's orders, dated October 1, nat he was to receive a serving of twice daily, as a nutritional e House Manager was reviewed. He said there was no tin the facility at the time but that | | 460 | | | |
| | Client #1 receive he (the House M facility on Octobe interview and redirect support st document the In record. Without could not confirm received the survey, in accommented that the last half of 2 in February 200 weight dropped | anager recalled having seen the supplement since the time (anager) began working in the er 2, 2007. However, further cord review revealed that the aff had not been instructed to stant Breakfast in the client's documentation, this surveyor in whether or not the client had eplement twice daily prior to the dance with physician's orders. The had weighed 58 lbs. during 1006. After he went to the hospital of 7 for "persistent diarrhea," his to 56 lbs. He held steady at 56 of 2007; however, he weighed 55 | | | | | |

| ND PLAN C | F CORRECTION | IDENTIFICATION NUMBER: | PPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI IN NUMBER: A. BUILDING COMPLETED | | | | |
|--------------------------|--|---|--|----------|---|----------------------------|---------|
| | *** | 09G058 | B. WIN | G | | 10/ | 12/2007 |
| SYMBRA | ROVIDER OR SUPPLIER | | | 521 K | ADDRESS, CITY, STATE, ZIP COL ENNEDY STREET, NE HINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | (| PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | (X5) COMPLETION DATE | |
| W 460 | 2007. A 4 lb. loss drop in overall bo 2. According to C dated October 1, nutritional suppler served in between | and dropped to 54 lbs. in July in weight represents a 6.9% | W 4 | 60 | | | |
| | a. Dinner was ob 10, 2007. The more french fries, mixe for dessert. At ap began to stand up even though more remained on the person asked him responded with "I request that he si two more bites of at 6:32 PM, at wh presented him with Boost supplement into a glass and him with the side of the s | served in the facility on October eal consisted of hamburgers, d vegetables and fruit cocktail proximately 6:29 PM, Client #2 of from his dining room chair, e than 50% of his meal plate. A direct support staff to "eat a little more." He don't want." She repeated her than and eat, and he did. He ate vegetables. He stopped eating lich time another staff person his can of strawberry flavored to the supplement e finished it within seconds. The client left the | | | | | |
| | October 11, 2007 The client began of 1:36 PM, the day indicated that the supplement daily indicated that the of significant weight thought he was "o | bbserved at his day program on between 1:12 PM - 2:45 PM. eating his lunch at 1:24 PM. At program Activities Coordinator home sent a can of Boost with the client. He further client had experienced a period ht loss previously; however, he oing much better these days." | | | | | |

| STATEMENT AND PLAN C | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | /ULTI | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|-------------------|-------|---|---|-----------------------------|
| | | 09G058 | B. WI | NG_ | | 10/1 | 2/2007 |
| SYMBRA | Provider or Supplier AL | | | 5 | REET ADDRESS, CITY, STATE, ZIP CODE 21 KENNEDY STREET, NE VASHINGTON, DC 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAC | IX | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | (X6) COMPLETION DATE |
| W 460 | #2 with his lunch a Boost after he finis approximately 2:33 program registered client's appetite flu that "he loves swe 3. As noted in the determined on Oct had not received h supplement during AM, the House Ma also was to receive Client #4 was not of supplement during Manager nor direct this supplement as regimen, there was home on October not instituted a forr | dded that she gave him the shed his lunch. At 7 PM, interview with the day d nurse revealed that the ctuated from day to day and ets." first paragraph above, it was tober 12, 2007 that Client #1 is prescribed Instant Breakfast the survey period. At 10:09 unager indicated that Client #4 e Instant Breakfast, once daily observed receiving the the survey, neither the House the survey, neither the House the survey, neither the House to support staff had mentioned is part of the client's dietary is no Instant Breakfast in the 12, 2007 and the facility had mal means for staff to | W | 460 | W460.3 Symbral has developme to document the delivery of pres nutritional supplement to the ind Staff have been inserviced and v to the House Manager and QMI supplied are not available. House and QMRP will monitor to ensu compliance. | scribed lividual. vill report RP if the e Manager | 10/26/07 and ongoing. |
| | accordance with hi | im the Instant Breakfast, in s physician's orders. | | | | | |

| AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA MBER: | (X2) MULT A. BUILDIN B. WING | IPLE CONSTRUCTION | (X3) DATE S COMPL | |
|--------------------------|--|--|---|------------------------------------|---|-------------------------------|--------------------------|
| NAME OF E | PROVIDER OR SUPPLIER | 09G058 | STREET AD | | OTATE 710 0000 | 10/1 | 12/2007 |
| SYMBRA | | | 521 KENN | NEDY STRE STON, DC 2 | STATE, ZIP CODE ET, NE 0011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| 000 | INITIAL COMMEN | TS | | 1 000 | | | |
| I 002 | 10, 2007 through (sample of two resiresident population degrees of disability added for a focuse management plan regimen. The find on observations at programs, interview one resident's medical and including incident resident res | • | random om a ious was rior dication re based two day staff and | 1 002 | I002.a Cross refer to W15 | 9 and W436.1 | 12/15/07 |
| · | shall demonstrate the provisions of D Title 6, Chapter 19 | nsee and residence d that he or she unders C. Law 2-137, D.C. (govern the care and persons in addition to | tands that Code, rights of | 6 6 6 6 6 6 | and adopted | | 12010 |
| | Surveyor: 17815 Based on observation review, the GHMR director failed to defend understood that the 13 of the D.C. Code, 2-137, D.C. Code, | met as evidenced by tions, interviews and r P licensee and reside emonstrate that he or e provisions of Title 7, e (formerly called D.C Title 6, Chapter 19) g mentally retarded perside: | ecord nce she Capter C. Law | | | | |
| | · · | to demonstrate prote | ection of | | | | |
| | ation Administration Y DIRECTOR'S OR PROVI | WALL HANDERSUPPLIER REPRESEN | TATIVE'S SIGN | vel NATURE | TITLE CEO | | (X6) DATE |

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f continuation sheet 1 of 49

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER | | | A. BUILDII | | (X3) DATE SURVEY COMPLETED | | | | |
|--|--|---|---|---|---|--------|--------------------------|--|--|
| | | 09G058 | - | B. WING | | 10/1 | 2/2007 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | 521 KENN | ADDRESS, CITY, STATE, ZIP CODE NNEDY STREET, NE NGTON, DC 20011 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE | | |
| 1 002 | both in accordance Plans (ISPs) [Title formerly § 6-1964(c) A. During observate 2007 and at breakf. Resident #1 ate with spoon with a blue at Review of the reside 2007 revealed that plastic-coated spoor inquiry at 7:18 PM, spoon (pink) which resident during the in-service training rethat the staff observice. | receive habilitation, of with their Individual 7, Chapter 13, § 7-13 c)], as follows: tions at dinner on Octast the following morth a small (child-sized and green plastic hand ent's record on Octohe was prescribed a confort use at all meals staff presented a conhad not been used becords revealed no eved working with the 11, 2007 had receive | Support 305.04(c), tober 10, ning, dle. ber 12, s. Upon ated by the taff evidence resident | 1002 | I002.b Cross refer to W159 and and adopted | W436.2 | 12/15/07 | | |
| | Also see Federal D W159 and W436.1 | eficiency Report - Ci | tations | | | | | | |
| | evening of October morning, followed to and then additional (October 11, 2007) the resident observe while he moved about the compart of the moved about the mo | s observed in the hor 10, 2007 and again by day program observations that affin the home. At no ted using elbow of knowt 'on all fours.' Howeview of Resident #'07, revealed: "elbow ibed to prevent injurys he uses his elbows then indoors <cli>client's alion when indoors." and he required staff and At 7:08 PM, two dasked about the pads at the pads should be</cli> | the next rivations ternoon time was ee pads wever, on 1's ISP, and knee / to these s and s name> At 5:10 assistance irect s. They | | | | | | |

| IDENT | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---|--|--|-------------------------------|--------------------------|
| | | 09G058 | | B. WING_ | | 10/1 | 2/2007 |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | 1011 | . 21 2401 |
| SYMBRA | AL . | | 521 KENI WASHING | NEDY STRE STON, DC 2 | ET, NE 20011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 1 002 | Continued From pa | age 2 | | 1002 | | | 1 |
| | interview revealed should wear them staff in-service trai evidence that the sresident on Octobe received training of elbow and knee page 15 and 15 an | Deficiency Report - Ci | are that he eview of dono g with the ad ctive | | | | , |
| | C. Staff interview and review of in-service training records revealed that staff had not received training on the use of Resident #1's "Elbow Comfy Splint" that remained in it's shipping carton. Staff also confirmed that the item had been received in late May 2007, as per the date marked on the shipping label. Also see Federal Deficiency Report - Citations W159 and W436.3. | | | I002.c Cross refer to W159 and adopted | 1 W436.3 | 12/15/07 | |
| | D. The facility fails competency in imp shoulder exercise October 12, 2007, PT assessment, do revealed that the precommended a slinvolving the use of a pulley for program. At 7:35 and the recently-hi a shipping box that shoulder exercise review revealed that delivered in Februar | ed to ensure staff dispolementing Resident approgram using a puller review of Resident atted February 27, 200 hysical therapist had noulder exercise proof a pulley. Observation of previously indicated resident's exercise PM, two direct supported House Manager pulley. Further intervat (a) the pulley had bary 2007, (b) to date, sed the pulley, (c) sta | #2's On 2's annual 27, gram ons and ated the e ort staff oresented #2's iews and been the | | I002.d Cross refer to W159 and and adopted | W436.3 | 12/15/07 |

| STATEMEN AND PLAN (| T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | R/CLIA MBER; | A. BUILDIN | | (X3) DATE SI COMPLE | |
|--------------------------|--|---|---|-----------------------|---------------------------------|---------------------------------------|----------|
| | | 09G058 | | B. WING _ | , | 10/1: | 2/2007 |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, | STATE, ZIP CODE | 10111 | |
| SYMBRA | L | | 521 KENN WASHING | EDY STRE TON, DC 2 | ET, NE 0011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | (X5) COMPLETE DATE | | |
| 1 002 | Continued From pa | ige 3 | | 1 002 | | · · · · · · · · · · · · · · · · · · · | |
| 1002 | been trained on the "someone" (staff no up at a previous statraining (date not spin-service training has been properly and W436.3. E. The facility failed necessary informat proper implementar Resident #1's commander the was no evided with staff to decide questions they were implementing the properly down the whand/of accordance with the speech/language the sign to document the question but did no response, as indicated House Manager and not received training language therapist implement the residence that staff to implement the residence that staff to implement the reprograms. Also see Federal D | e proper use, and (d) of sure who) had not aff meeting for in-sen pecified) and no addinad been provided to efficiency Report - Cir | vice tional date. tations had the isure ion of rogram. had met or how when not writing asked, in by the ed a + sident a ent's The they had ech/ v to n nowed no on how tion | 1002 | I002.e Cross refer to W159.8 an | d adopted | 12/15/07 |
| | F. The facility failed follow-up for Reside at 4:13 PM, review revealed that he red | d to ensure timely de ent #1. On October of Resident #1's den ceived a dental asset 6. On October 4, 200 | ntal 12, 2007, tal record | | | | |

| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | A. BUILDII | | RUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|--|-------------------------|-------------------|--|-------------------------------|--------------------------|
| | | 09G058 | | B. WING | | | 10/ | 12/2007 |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP C | ODE | | , |
| SYMBRA | AL ` | | | NEDY STRE STON, DC 2 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM | ' FULL | ID PREFIX TAG | (EAC | ROVIDER'S PLAN OF COP H CORRECTIVE ACTION G-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| 1002 | and recommended submit pre-authori resident's record of dentist on June 6, found "moderate or recommended "passubmit pre-authori review of the residence that he scaling, one year a Interview with the to date, the reside performed and the scheduled. II. The facility faile residents' rights to well-balanced, varwhere ordered by to a specialized dia 7-1305.05(f), form A. Resident #1 wall Instant Breakfast in orders and there we facility on October the newly-assigned support staff said the supplement. Freview revealed the not been instructed Breakfast in the redocumentation, this whether or not the supplement twice accordance with personal residents in the redocumentation with personal residents. | d "heavy calculus del d "patient needs scalin zation to Medicaid" locumented a return valour, at which time the falculus deposits" and atient needs scaling zation to Medicaid" ent's record that day re received the recomafter it was first prescribed to demonstrate progree was no return apprend and appetizing die a physician and/or nuet [Title 7, Chapter 13 erly § 6-1965(f)], as for a coordance with physician so Instant Breakfa 12, 2007. When inted House Manager and the resident normally lowever, interview an at the direct support so to document the Insistent's record. With a surveyor could not resident had received daily prior to the survey hysician's orders. | rg will The Visit to the he dentist will Further revealed mended ribed, aled that aling ointment tection of et, and tritionist, sollows: ving ysician's est in the reviewed, d direct received d record etant out confirm d the ey, in | 1002 | I002.f.I. adopted | Cross refer to w3 | 56 and | 12/15/07 |
| | it should be noted documented that h | that Resident #1's we le had weighed 58 lbs | eight chart | | | | | |

FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1002 Continued From page 5 1002 I002.f.II.a. b and c Cross refer to W460 10/26/07 the last half of 2006. After he went to the hospital and adopted and in February 2007 for "persistent diarrhea." his ongoing weight dropped to 56 lbs. He held steady at 56 lbs. through May 2007; however, he weighed 55 lbs. in June 2007 and dropped to 54 lbs. in July 2007. A 4 lb. loss in weight represents a 6.9% drop in overall body weight. B. According to Resident #2's physician's orders, dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Observations and interviews revealed that the Boost was not being offered between meals. Instead, the resident was offered Boost immediately after he refused to finish the foods served at meals in the home and at his day program. C. As noted in paragraph 2.a. above, it was determined on October 12, 2007 that Resident #1 had not received his prescribed Instant Breakfast supplement during the survey period. At 10:09 AM, the House Manager indicated that Resident #4 also was to receive Instant Breakfast, once daily. The resident was not observed receiving the supplement during the survey, neither the House Manager nor direct support staff had mentioned this supplement as part of the client's dietary regimen, there was no Instant Breakfast in the home on October 12, 2007 and the facility had not instituted a formal means for staff to document giving the resident the Instant Breakfast, in accordance with his physician's orders.

W460

Also see Federal Deficiency Report - Citation

III. The facility failed to demonstrate protection of residents' rights to have their personal records.

| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|---|--|--|-------------------------------|--|--|
| | | 09G058 | | B, WING _ | | 10/1 | 2/2007 | |
| SYMBRA | ROVIDER OR ŞUPPLIER | | 521 KENN | DDRESS, CITY, STATE, ZIP CODE NEDY STREET, NE GTON, DC 20011 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY) | (OULD BE | (X5) COMPLETE DATE | |
| 1 002 | Continued From p | age 6 | | 1002 | | | | |
| | kept current, and maintained in a manner that protects privileged and confidential information [Title 7, Chapter 13, § 7-1305.12, formerly § 6-1972], as follows: A. On October 10, 2007, at 5:35 PM, a note was observed posted openly on a cabinet door in the kitchen. Review of the note revealed that it included Resident #2's full name and a listing of foods that he was to avoid eating due to a medical condition. This practice failed to ensure the confidentiality of the residents' personal information. B. As per subsection (5), the facility failed to | | | | | | | |
| | | | oor in the lat it listing of o a to ensure | | I002.f.III.a, b, c,d, and e Cross W24, W143 and W148 and add | | 11/30/07 | |
| | ensure that Resid diagnostic proced he was evaluated specialist on Augu evidence of more procedures obser However, on Octofacility sent to the transmittal that indiagnostic report had not been in the of the survey. The #2 underwent an September 20, 20 Across the top of 'electronic stamp' facility earlier that | tion (5), the facility fai ent #2's record reflectures. The record reflectures. The record reflectures. The record reflectures agastro-intestinal ast 21, 2007. There we recent appointments ved in the resident's rober 16, 2007 (post-suber 16, 2007 (post-suber 16, 2007) among other idated September 20, are resident's record at the report indicated that apper GI series examulated to a hospital radio the diagnostic report indicating that it was same day (October 1 fter the procedure was | ted all ected that (GI) /as no or ecord. urvey), the n a fax tems, a 2007 that the time t Resident ination on logy clinic. was an sent to the 6, 2007), | | | | | |
| | notations added t report. Whoever | I that there were 2 had the bottom of the did made those entries (i i) had neither signed r | agnostic n the | | | | To the state of th | |

alth Regulation Administration
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| STATEMEN AND PLAN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | A. BUILDIN | PLE CONSTRUCTION | (X3) DATE S COMPLI | |
|--------------------------|--|--|--|------------------------|---|--------------------------------|--------------------------|
| | · | 09G058 | | B. WING _ | | 10/1 | 2/2007 |
| NAME OF F | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, 8 | STATE, ZIP CODE | | |
| SYMBRA | AL | | 521 KENN WASHING | EDY STREI TON, DC 2 | ET, NE 0011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| | Qualified Mental Re (QMRP) failed to do revise habilitation p #2 successfully cord. D. As per subsective show evidence during were with Resident experienced a seizedocumented the sign seizure report form policies. The only it his seizure had last subsequently taken room for evaluation. On October 16, 200 sent to the Department to the Department that included, amore form. The form was described in greate symptoms of a seizexperienced. Furth a space designated been signed by the The faxed materials. | on (7), the facility's A etardation Profession ocument the review oblans once Residents in the program of the survey that still at the time that have on May 28, 2007 and symptoms or in accordance with information available that 5 minutes and he in to a hospital emergination of Health a fax the gother items, a seizes dated 5/2 <sic> and the formation available that the signs and sure that Resident #1 in the review of the formation of the formation available that the signs and the signs are signs and the signs and the signs are signs are signs are signs and the signs are sic> | nal of, and/or i #1 and rams. ailed to aff who e had n a agency was that e was ency facility ransmittal cure report d in revealed MD" had LPN. source of | 1002 | | | |
| | E. As per subsection review revealed no established a policy how facility staff shand/or communication involved family mer | on (14), interviews as evidence that the fact and procedure that ould document each tion with guardians as mbers. | cility had specified contact nd/or | | | | |
| | Also see Federal D W124, W143 and V | eficiency Report - Ci V148 | tations | 1 | | | |

| | TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE (DENTIFICATION NU | | R/CLIA MBER: | A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--|---|---|-------------------------------|----------------------------|
| | · | 09G058 | | _l | | 10/12 | 2/2007 |
| SVMBBAI 5 | | | | EDY STREI | BTATE, ZIP CODE ET, NE 0011 | | , |
| (X4) ID PREFIX TAG | X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE | | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | |
| 1.020 | 3501.3 Each GHMF walking distance of demonstrate that it its residents to the (I) Similar facilities. This Statute is not Surveyor: 17815 Based on resident averification, the GH opportunities to par of choice, to meet to residents in the sar. The findings included the included of the opportunities and plays assessed interest, a. On October 12, PM, review of Residents in the sar. a. On October 12, PM, review of Residents in the sar. The findings included the opportunities and plays assessed interest, a. On October 12, PM, review of Residents in the sar. Review of his IPP representational activities the sar. Review of his IPP recreational activities further review of the failed to outline pot choice. Review of outlings/ recreations. | met as evidenced by and staff interviews a MRP failed to providiticipate in communition needs of two of the program revealed a service ob participate in a minimes per month." Howe e program revealed to the resident's communicational activities record read been to a live the additional activities record read been to a live the and service of the resident's communicational activities record read been to a live the additional activities record read been to a live the additional activities record read to provide the activities record read been to a live the activities record read to a live the activi | sy n or rtation for and record e y outings ne two and #2) #1 was eatre n his following: ely 4:10 Support aled the oing to olays." jective in num of 4 ever, that it stivities of unity vealed no | 1020 | I020.1.a and 2 Cross refer to d and adopted | W136.1.a | 12/15/07 and ongoing |

FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 9 020 b. At 5:04 PM, the resident was interviewed in his bedroom. He confirmed that he enjoyed attending live theatre performances but had not had the opportunity to do so. c. At approximately 5:30 PM, interview with the recently-hired House Manager revealed that he was unaware of how community outings were selected. d. At 7:19 PM, interview with 2 direct support staff persons revealed that Resident #1 enjoyed going to the Chateau nightclub on Thursday nights. His record did not, however, reflect outings to the Chateau in recent months. The staff acknowledged that the most recent outing to the Chateau was documented on March 29, 2007. Staff routinely selected activities and the four residents usually went together. They further indicated that since the March 29, 2007 outing to the Chateau, requests for accessing the resident's personal funds to pay for admission to the nightclub (or other activities that cost money) had not been acted upon by administrators at the corporate office. Review of the resident's documented outings revealed that they consisted of outings to parks, supermarkets, shopping malls and/or driving past monuments and government buildings ("sightseeing"), all at no cost. Subsequent review of the resident's financial records for the 9-month period December 31, 2006 - September 28, 2007 revealed that except for a 6-day vacation to Ocean City, MD at the end of July 2007, the resident had not spent any personal funds for anything, community outings included. (Note: According to a bank statement dated September

\$1,000.)

28, 2007, his bank balance was more than

| STATEMENT IND PLAN C | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | R/CLIA MBER: | A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SI COMPLE | |
|--------------------------|---|--|--|---------------------|---|------------------------|-----------------------------|
| | <u> </u> | 09G058 | · · · · · · · · · · · · · · · · · · · | ļ. <u>.</u> | | 10/1 | 2/2007 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| SYMBRA | L | | 521 KENNE WASHINGT | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| I 020 | record of community group outings that of activities document parks, supermarke past monuments at record did not reflepersonal choice an attend social, religionactivities. | 2007, review of Resity outings revealed a consisted of the samed for Resident #1, respectively. The same set of the same set o | dent #2's listing of e namely driving ings. His ngs of lities to oup | 1020 | | | |
| I 024 | SPACE Each GHMRP shall outside recreationa | met as evidenced by | vide | 1 024 | I024 Cross refer to I020.1.a - I020.2 and adopted | d and | 12//15/07 and ongoing |
| I 040 | ' | VICE / DINING ARE. I provide each reside lanced diet. | | I 040 | | | |
| | Surveyor: 17815 Based on observat review, the GHMRI | met as evidenced by ion, interview and red P failed to provide a accordance with phaye: | cord | | | | |
| | Resident #1 was Instant Breakfast in | s not observed received | ving | • | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1 | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | [' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---|-------------------------|--|-------------|-------------------------------|--|
| | | 09G058 | | B. WING _ | | 10/1 | 12/2007 | |
| NAME OF F | ROVIDER OR SUPPLIER | .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | STATE, ZIP CODE | | | |
| SYMBRA | | | | IEDY STRE ITON, DC 2 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE OF MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | |
| I 040 | orders and there vertically on October the newly-assigne support staff said the supplement. It review revealed the not been instructed Breakfast in the redocumentation, the whether or not the supplement twice accordance with public last half of 200 in February 2007 weight dropped to lbs. through May 2 lbs. in June 2007 | vas no Instant Breakfa 12, 2007. When intered House Manager and the resident normally flowever, interview and at the direct support of the direct support of the direct support of the direct support of the Instance resident's record. With its surveyor could not be resident had received daily prior to the surveyor sident's orders. I that Resident #1's we he had weighed 58 lbs of the went to the for "persistent diarrhe of 156 lbs. He held stead 2007; however, he we and dropped to 54 lbs in weight represents | erviewed, d direct received d record staff had stant hout confirm d the ey, in eight chart s. during he hospital a," his dy at 56 highed 55 in July | I 040 | I040.1,2 and 3 Cross referadopted | to W460 and | 10/26/07 and ongoing | |
| | According to Resident #2's physician's orders, dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Observations and interviews revealed that the Boost was not being offered between meals. Instead, the resident was offered Boost immediately after he refused to finish the foods served at meals in the home and at his day program. As noted in paragraph 2.a. above, it was determined on October 12, 2007 that Resident #1 had not received his prescribed Instant Breakfast supplement during the survey period. At 10:09 AM, the House Manager indicated that Resident #4 also was to receive Instant Breakfast, once daily. Resident #4 was not observed receiving | | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLII IDENTIFICATION NU | | R/CLIA MBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|---|---|--|---------|----------------------------|
| NAME OF T | DOMESTIC OF THE PARTY OF THE PA | 09G058 | | | | 10/1 | 2/2007 |
| SYMBRA | <u></u> | | 521 KENN WASHING | DRESS, CITY, STATE, ZIP CODE NEDY STREET, NE STON, DC 20011 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | |
| I 047 | House Manager not mentioned this supdietary regimen, the the home on Octobe had not instituted a document giving he accordance with his 3502.5 MEAL SER Each GHMRP shathat meals, which a GHMRP, are suited residents as indicated Habilitation Plan. This Statute is not Surveyor: 17815 Based on observatively, the facility if #2 received Boost between meals, where the finding included According to Resident According to Resident October 1, 2 nutritional supplemental suppleme | aring the survey, neither direct support staff oplement as part of the ere was no Instant Broser 12, 2007 and the factorial means for state in the Instant Breakfatis physician's orders. RVICE / DINING ARE/ Il be responsible for eare served away from do to the dietary needs atted in the Individual at met as evidenced by tion, interview and reclailed to ensure that Finutritional supplemental end was at day pro- | had e client's eakfast in facility aff to ast, in AS nsuring the of cesident it in gram. rders, ed Boost to be the day t being offered re was no ed en | 1040 | I047 Cross refer to W460 and | adopted | 10/26/07 and ongoing |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G058 | | | (X2) MULT A. BUILDIN B. WING | | (X3) DATE SURVEY COMPLETED | | | |
|---|--|--|---|-----------------------------------|---|------------|----------------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, | STATE, ZIP CODE | 101 | ZIZUUI | |
| SYMBRA | L | | | NEDY STREET, NE GTON, DC 20011 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COME (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE | |
| 1 052 | Continued From pa | ge 13 | | 1.052 | | · | | |
| l 052 | Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: Surveyor: 17815 Based on observation, interview and record review, the GHMRP failed to ensure that Resident #1's coated spoon was made available for use at all meals. | | | 1 052 | I052 Cross refer to W194.a ar | nd adopted | 10/24/06 and ongoing | |
| | | | s | | | | 05 | |
| | | | ord It | | | | | |
| | was observed eating metal spoon with a The resident was o spoon at breakfast 12, 2007, at 4:05 P Individual Support I 2007, revealed that spoon. At 7:18 PM asked asked about presented a teaspostated that this was presented to the re | s: O7, at 6:28 PM, Resider with a small (child-blue and green plassibserved using the sathe next morning. OM, review of Resider Plan (ISP), dated Marche was prescribed a PM, a direct support the coated spoon. Son with a pink coating the spoon she always ident. The pink-coated previously | sized) tic handle. Impelittle on October of #1's rch 21, a coated t staff was She g and ys ated | | | | | |
| l 061 | the survey. 3502.19 MEAL SER Each GHMRP shal | RVICE / DINING ARI I have effective proce ent and work areas | EAS | i 061 | | | | |

| STATEMEN AND PLAN (| FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | R/CLIA MBER: | A. BUILDIN | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED | | |
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| | | 09G058 | | B. WING_ | | 10/1 | 2/2007 |
| NAME OF P | ROVIDER OR SUPPLIER | | | · · · · · · · · · · · · · · · · · · · | STATE, ZIP CODE | | · |
| SYMBRA | L | | | KENNEDY STREET, NE SHINGTON, DC 20011 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| I 061 | Surveyor: 17815 Based on observation implement effective and sanitary equip food preparation a The findings include On October 12, 20 inspection of the kind. 1. dried/ hard food on 3 out of 12 bow above the stove; a | met as evidenced by tion, the facility failed e procedures to ensument and work areas nd serving. The control of the control | to re clean used for 3:00 PM, ncrusted abinet | 1 061 | I061.1 and 2 Staff have been in on 10/26/2007 on the cleaning and of food and the clean of all utensil equipment and surfaces in the kite House Manger will monitor on a rebasis and as needed to ensure com QA will monitor quarterly. | d storage s, hen area. nonthly | 10/26/07 |
| l 062 | Dishes and eating each meal and sto condition. | RVICE / DINING ARE utensils shall be clea red to maintain their s met as evidenced by above | ned after sanitary | I 062 | I062 Cross refer to I061 and adop | ted. | 10/26/07 |
| I 072 | Each bedroom sha following items for (a) Standard single This Statute is not Surveyor: 17815 | OMS AND BATHROG all be equipped with a each resident: e or twin-sized bed; t met as evidenced by tion, the facility failed | t least the | 1072. | | | |

| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIEI IDENTIFICATION NUM 09G058 | R/CLIA MBER: | (X2) MULT A. BUILDIN B. WING | IPLE CONSTRUCTION | (X3) DATE SU COMPLE 10/12 | |
|--------------------------|--|--|--|--|---|--|--------------------------|
| IAME OF P | ROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | |
| SYMBRA | L . | | | KENNEDY STREET, NE SHINGTON, DC 20011 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE |
| 1072 | The findings included. 1. On October 12, mattress on Reside concave in the cera dequate support. That he intended to another one that we commended on of his bed be elevated indicated that reflux and gastritis however, revealed. | nattress suitable to m dent. | e ken, ovide r stated s with I nearby. alist had the head nedical blems with nterviews, bed was | 1072 | I072.1 Individual # 3 mattreplaced on 10/12/2007 with continuous into service. A new mattress into service on 10/22/2007. H Manager will inspect mattress basis to ensure that equipment condition. QA will monitor quality. Individual #2. bed has the G.I. Specialist recommend 10/13/2007. DON and QMRF that all positioning orders are edirected. | me that was was brought ouse on a monthly in good arterly basis. been raise per ation on will ensure | 10/22/07 |
| 1'075 | , , | OMS AND BATHROG all be equipped with a each resident: | | i 075 | | · | |
| | Surveyor: 17815 Based on observa a night stand for e The finding includ On October 12, 20 stand was found i | | to provide one night | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G058 | | ER/CLIA MBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|--|--|-------------------------------|----------------------------|----------|
| NAME OF F | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | 10/1. | 2/2007 |
| SYMBRA | WASHINGTON, DC 20011 | | | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY) | IOULD BE | (X5) COMPLETE DATE | |
| 1 075 | Continued From p | age 16 | | I 07 5 | I075 The night stand was re | nlaced and | 11/30/07 |
| | present was missi | ng a drawer. | | | another placed in the room | paroud and | 11/30/07 |
| l 082 | 2 3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. | | I 082 | I082 An individual that lives in removes the paper towels and contact bathroom. Cups have been place bathroom. Individual is being transing the items appropriately. | ups from the | 11/30/07 and ongoing | |
| | Surveyor: 17815 Based on observa properly equip ead appropriate items The finding include On October 12, 20 | 007, at approximately re available in the cup | ed to t's needs. 3:28 PM, | | | | |
| 1 090 | 3504.1 HOUSEKE | EPING | | 1 090 | | | |
| | maintained in a sa and sanitary mann | xterior of each GHMR afe, clean, orderly, attr ner and be free of dirt, rubbish, and obje | active, | | | | |
| | Surveyor: 17815 Based on observa | t met as evidenced by ition, the GHMRP faile y in a safe, clean, ord | ed to | | | | |
| | The findings include | de: | | | | | |

| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | (X2) MULT A. BUILDIN B. WING | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------|------------------------------------|--|-------------------------------|--|
| VAME OF P | ROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY, | STATE, ZIP CODE | 10/1/ | 212001 |
| SYMBRA | AL | | | NEDY STRE STON, DC 2 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 1 090 | A walk-through inspection of the facility, conducted on October 12, 2007, beginning at 2:50 PM, revealed the following: Living Room: 1. A segment of a baseboard, approximately 14 | | | 1 090 | I090 Living Room 1. The base-board has been 10/16/2007 2. The 2 side chair have been disposed. 10/13/2007 Dining Room The Dining Room Chair are replaced by 11/30/2007. Kitchen: | n | |
| | the wall behind the 2. One of the 2 sides | as peeled outwards, a recliner. de chairs (black/purple tear in the upholstery. | e/blue | 1. | Cross refer to I061 and adopted The Basement The rug was removed from service Resident#3 Bedroom: The toothbrushes were replaced and | | 10/26/2007 10/12/2007 10/14/2007 |
| | Dining Room: 1. Two of the 4 chairs at the dining room table (black upholstery) had tears in the upholstery. | | n table Istery. | · | storage case purchased. Resident#2 and #4 Bedroom 1. The toothbrushes were repstorage case purchased. | | 10/14/2007 |
| | Kitchen: 1. see Citation 106 | | | | 2. The bed spread was remove service on 10/12/2007 and replaced | ed from | 10/14/2007 |
| | The Basement: 1. The edges on two areas rugs were curled | | | | 3. Cross refer to I075 and ad- | opted. | 11/30/2007 |
| | upwards, presentir | ng a potential trip haz nmediately rolled up a | ard. The | : | Exterior. The side ramp is be repaired. | ing | 11/30/2007 |
| | Resident #3's Bedroom: 1. Resident #3's toothbrush was stored openly in | | | | The house manager has been instruct check these and all areas in the home monthly basis. Maintenance personn | e on a el will | |
| | his toiletry. The to and other potential Residents #2 and i | oth brush was expose I contaminants. | ed to dirt | | complete any structural repairs. Staff inserviced to report any defect/need immediately. QMRP will monitor to compliance. | s | |
| | Two were stored o | piletry kit held 3 toothl penly in the kit, there lirt and other potential | by leaving | | | | |

| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED | | | |
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| | | _09G058 | | <u> </u> | | 10/12/2007 | | |
| SYMBRA | ROVIDER OR SUPPLIER | | 521 KENNE | ODRESS, CITY, STATE, ZIP CODE NEDY STREET, NE GTON, DC 20011 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE COMPLETE | | |
| 1090 | contaminants. The protective case; ho upon opening the case; ho upon opening the case; ho upon opening the case. The bed spread immed as a large of the case of th | e third toothbrush was wever, a foul odor was wever, a foul odor was ease. I on Resident #2's be House Manager remiately. In 1075 above ower landing portion of eading to the spot where a parked overnight was ed across it. There in either side of the love with protruding in a local weeker and electric experiences. | of the ere the was old gged were wer | 1 090 | | | | |
| 1094 | Adequate and app provided for each 3502.17, each piece each supply, utensitem. This Statute is no Surveyor: 17815 Based on observatialed to ensure approximately for linens. The finding include On October 12, 20 inspection of the resistance in t | ropriate storage shal food item in accordar ce of cleaning equipn sil, linen, or other hou t met as evidenced b tion and interview, th opropriate storage wa | nce with § nent, and isehold y: e GHMRP as provided | I 094 | I094 Storage of the linen close we organize so that the individual suppled designated for their personal use only. A padlock was placed on the storage for cleaning agents on 10/13/2007. | ies are y. ge cabinet | | |
| alth Regu | lation Administration RM | | 6 | 800 | AEOI11 | If continuation sheet 19 of | | |

| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | (X2) MULTIPI A. BUILDING B. WING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| NAME OF P | ROVIDER OR SUPPLIER | <u> </u> | STREET ADD | RESS, CITY, ST | ATE, ZIP CODE | | 2,2001 | |
| SYMBRA | AL | | | EDY STREET TON, DC 200 | | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | | |
| 1 094 | Continued From pa | age 19 | | 1094 | | | | |
| | that towels, wash clothes and sheets were not stored in a manner that identified individuals' names. The House Manager confirmed that the residents shared towels, wash clothes and bed sheets. The facility had not established a means to ensure that each resident had a supply of linens designated for their personal use only. | | | | | | | |
| 1 095 | 3504.6 HOUSEKE | EPING | | 1 095 | | | | |
| | | austic agent shall be nd shall be out of dire | | | | | | |
| | Surveyor: 17815 Based on observa- failed to ensure that | t met as evidenced b tion and interview, th at poisonous and/or o d in a locked cabinet | e GHMRP caustic | | · | | | |
| | The finding include | es: | | | | | | |
| · | inspection of the b that held cleaning The House Manag routinely used the | e06, at approximately asement revealed a agents was not without the residence of the real which was near and dryer. Resident real ater that day. | cabinet out a lock. ent #4 ir the | | | | | |
| 108 | 3504.15 HOUSEK | EEPING | | l 108 | | | | |
| | 7 | all assure that each rechanges of clothing a activities. | | | | | | |

This Statute is not met as evidenced by:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLII IDENTIFICATION NU 09G058 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SU COMPLE - 10/12 | | | |
|---|--|--|--|---|---|--------------------------------|--------------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP CODE | | | | |
| SYMBRAL WASHING | | | 521 KENN WASHING | EDY STREE ION, DC 20 | | | | |
| (X4) ID PREFIX TAG | REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE | |
| I 108 | Surveyor: 17815 Based on observation and interview, the facility failed to ensure that each resident was provided with at least seven changes of appropriate clothing. The findings include: A walk-through inspection of the facility, conducted on October 12, 2007, beginning at 2:50 PM, revealed the following: 1. Three out of 7 undershirts in Resident #3's dresser drawers had holes in them or were frayed at the collar. The House Manager immediately removed the shirts from the dresser drawers. The resident did not have al least 7 undergarments in good repair. | | J 108 | It is a Clothing items have been replaced for individual #2 and #3. House manager will monitor on a monthly basis the number and the condition of the clothing available and will replace these items to ensure that adequate supplies are available at all time. QMRP will monitor. QA will monitor on a quarterly basis. Administration will receive a monthly report from the House manager on the clothing needed of the individuals. | | 10//24/07 | | |
| | dresser drawers h frayed collars. The removed the shirts The resident did n undergarments in | good repair. eficiency. See State I | or had mediately awers. | | · | | | |
| l 110 | | EEPING all ensure that each re good condition, laund | | l 110. | I110 Cross refer to I108 | and adopted. | 10/24/07 | |
| | This Statute is no Surveyor: 17815 see Citation I108 a | t met as evidenced b above | y: | , | | | | |

alth Regulation Administration
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| TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUMBER 109G058 | | | (X2) MULTIF A. BUILDING B. WING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED . 10/12/2007 | | |
|--|--|---|---------------------------------------|---------------------|---|----------|--------------------------|
| IAME OF P | ROVIDER OR SUPPLIER | | STREET ADDR | | TATE, ZIP CODE | 1000 | |
| | | | WASHINGT | | | | |
| (X4) ID PREFIX TAG | | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| I 111 | Continued From pa | ige 21 | | 1111 | | | |
| I 111 | 3504.18 HOUSEKE | EEPING | į | 111 | | | |
| | procedures to ensure by assisting the rest or by performing the | l establish sorting and tre adequate sanitation sidents to perform the e tasks for the reside fir Individual Habilitati | on either ese tasks ents as | | | | , |
| | Surveyor: 17815 Based on observat failed to establish a | met as evidenced by ion and interview, the a system to ensure the clothing items were | e facility at each | | | | |
| | The findings includ | e: | | | | | |
| | shorts with Reside Resident #3's dres Manager said Resi room with Residen | 07, at 3:29 PM, a paint #4's initials was obser drawers. The Hodent #4 used to shart #3. The House Mayed the shorts from R | served in buse e the nager | | | | |
| I 135 | 3505.5 FIRE SAFE | ΞΤΥ | | 1 135 | | | e e |
| | | ll conduct simulated if fectiveness of the place ar for each shift. | | | | | |
| | Surveyor: 17815 Based on record re | t met as evidenced by ecord review, the fact drills quarterly on all | lity failed | | | | |

| -74754514 | | T . | | | | | |
|--|---|---|--|-----------------------------------|--|--------------------------------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIDENTIFICATION NOT 100 NO | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | IR/CLIA MBER: | (X2) MULTIP A. BUILDING B. WING | PLE CONSTRUCTION | (X3) DATE S COMPL | LETED |
| NAME OF F | PROVIDER OR SUPPLIER | 096058 | STORET AD | | | 10/ | 12/2007 |
| | | ! | L | | TATE, ZIP CODE | | |
| SYMBRA | \L | | WASHING | NEDY STREE STON, DC 20 | 1, NE 011 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | 'FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETE DATE |
| l 135 | Continued From pa | age 22 | | l 135 | | | |
| | The finding include | es: | | | | | |
| | reviewed for the 12 1, 2006 to August 3 documented evider conducted, on any period between Fel 2007. Records did July 2007, the facili timely on each shift This is a repeat def Deficiency Report, Citation W440 | ficiency. See Federa dated December 29, | ptember is no re month uly 29, at since e drills | | | | |
| l 169 | 3507.4(g) POLICIE | ES AND PROCEDUR | ES | l 169 | | | |
| | The manual shall in procedures for at le | ncorporate policies ar east the following: | nd | | • | | |
| | management of fur behavior managem | hich covers clothing, nds, resident rights, d nent, services, parent ent, visitation, staff tredent work. | discipline, tal and | | | | |
| | Surveyor: 17815 Based on observati review, the GHMRI establish and imple | t met as evidenced by tion, interview and rec P's governing body fa ement policies and pro and guardian involve | cord ailed to ocedures | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED | |
|---|---|--|----------------------|-------------------------|---|--------|----------------------------|--|
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, S | TATE, ZIP CODE | 1 10/1 | 12/2007 | |
| SYMBRA | L · | | 521 KENN | EDY STREE TON, DC 20 | T, NE | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETE DATE | |
| I 1.69 | Continued From page 23 | | | l 169 | | ·/··· | | |
| | how facility staff should document each contact and/or communication with guardians and/or involved family members in the residents' records. Also see Federal Deficiency Report - Citations | | | | | | | |
| | W124, W143 and \ | W148 | | | | | , | |
| l 180 | 0 3508.1 ADMINISTRATIVE SUPPORT | | | I 180 | | | | |
| | Each GHMRP shall administrative supp needs of the reside Habilitation plans. | I provide adequate port to efficiently mee ents as required by the | et the | | | | | |
| | Surveyor: 17815 | met as evidenced by ency Report - Citation | | | | | | |
| l 189 | 3508.7 ADMINISTR | RATIVE SUPPORT | | I 189 | | | , | |
| | Each GHMRP shall funds received ar | l maintain records of nd disbursed. | residents | | | | | |
| | Surveyor: 17815 On October 12, 200 | met as evidenced by 07, review of Resider vealed the following: | nt #1's | | · | | | |
| | bi-weekly stipend c 23, 2007. There w indicating that his s | t deposit for Residen heck was documente as no documentation tipend/ paychecks re n deposited and/or a | ed on May ceceived | | | | | |
| | 2. There was a 3-r financial record, be | nonth gap in Resider tween September 29 | nt #1's 9, 2006 - | | | | | |

| | | (X1) PROVIDER/SUPPLIE | MBER: A. BUILDING | | PLE CONSTRUCTION | (X3) DATE S COMPL | | |
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| ··· ··· | · · · · · · · · · · · · · · · · · · | 09G058 | | B. WING _ | · · · · · · · · · · · · · · · · · · · | 10/1 | 2/2007 | |
| SYMBDAI | | | 521 KENN | RESS, CITY, EDY STRE TON, DC 2 | STATE, ZIP CODE ET, NE 0011 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | |
| l 189 | Continued From particle December 31, 200 3. Resident #1's firstatements etc.) was documents out of statements. | 6. nancial record book (as in general disarray | receipts, /, with | l 189 | | | | |
| l 203 | Each supervisor sh descriptions with en employment and an This Statute is not Surveyor: 17815 Based on review of | all discuss the conte ach employee at the t least annually there met as evidenced by personnel records, to ocument annual revie | beginning after. /: | I 203 | | · | | |
| | records revealed the (as well as other erreview of their job of (6) of the 10 direct S6 and S8) had be year. Of those 6 (lew as no evidence of descriptions for any hire. Note: On October submitted additional Review of the faxed evidence of job desaforementioned errors. | 07, review of personnet all 10 direct supported all 10 direct supported all 10 direct supported at time of support staff (S1, S2 en employed for longongtime) employees, fannual reviews of the of them, since their 15 and 16, 2007, the all documentation via didocuments reveale scription reviews for the staff and the series of the staff and the series of the staff and the series of the staff and the series of the staff and the staff an | ort staff red a hire. Six , S3, S5, ler than a there heir job time of e GHMRP facsimile. d no he 6 | | | | | |
| | Report dated Dece | mber 29, 2006 | icensure | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | R/CLIA MBER: | (X2) MULTI A. BUILDIN B. WING | | (X3) DATE SU COMPLE | | |
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| SYMBRA | L . | | | EDY STREETON, DC 20 | | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 1 206 | Continued From pa | ge 25 | | 1 206 | | | |
| 1 206 | 3509.6 PERSONN | EL POLICIES | į | l 206 | | | |
| | annually thereafter, certification that a h performed and that | or to employment an shall provide a phys lealth inventory has t the employee 's hea her to perform the re | ician ' s Deen alth status | | · . | , | |
| | Surveyor: 17815 Review of personne 2007 revealed no e certification/invento working with the res | met as evidenced by el records on Octobe vidence of a current ry for the following insidents: | r 12, health idividuals | | | | |
| ٠ | - 1 of the 4 nurses | (N1) | | | | | |
| | - the podiatrist (who within the group ho | provided services o me) | nsite, | | | | |
| | identified 8 addition (including consultin evidence of health and 16, 2007, the 0 documentation via certification for thos were not cited above documents, however | facsimile verifying cuse 8 individuals; there we. Review of the faxer, revealed no evide or the 5 employees li | ls) without ober 15 rrent efore they ked ence of | | | · | |
| • | This is a repeat def | iciency. See State L | icensure | | | | |

| | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIED IDENTIFICATION NUM | | A. BUILDIN | PLE CONSTRUCTION G | (X3) DATE SU COMPLE | |
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| _ | | 09G058 | | B. WING _ | | 10/12 | 2/2007 |
| SYMBRA | ROVIDER OR SUPPLIER | | 521 KENN | DRESS, CITY, (IEDY STREI TON, DC 2 | | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| I 206 | Continued From pa | • | | 1 206 | | <u> </u> | |
| 1 222 | training programs s This Statute is not Surveyor: 17815 | inuous, ongoing in-se cheduled for all pers met as evidenced by | onnel. | I 222 | Cross refer to W194 and ado | pted. | 12/15/20 07 |
| | verification, the GH continuous, ongoin were conducted for The finding include | · | e that programs | ; | | | |
| 1 227 | Each training programmed to, the follow (c) Infection contro This Statute is not Surveyor: 17815 During the Entrance 2007, at 11:05 AM, that the agency expression and CPR of 2007, review of empreyealed the follow 1. 4 out of 10 directions. | am shall include, but ving: I for staff and residen met as evidenced by e Conference on October the House Manager pected all staff assign to have current first ertification. On October ployee personnel reciploges to support staff (S5, Sevidence of receiving | ober 11, stated led to aid ber 12, cords | l 227 | 1,2 and 3: The administration ensure that staff update his/le Health, First Aid and CPR to and a valid copy is filed with personnel file. House Managaudit personnel files on a media basis and QA will audit on a quarterly basis. The QMRP administration will received audit and re-concile the infocto ensure that the records are current. | her raining in their ger will onthly and the these rmation | 11/30/07 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT | IPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| · | | 09G058 | | B. WING _ | | 10/1 | 2/2007 | |
| 1AME OF P | ROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | 1 <u></u> | | |
| SYMBRA | | | 521 KENNI WASHING | EDY STRE TON, DC 2 | ET, NE 0011 | | ı | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SCIDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) | ULD BE | (X5) COMPLETE DATE | |
| l 229 | Report dated Decei 2. 4 out of 10 direct S10) were without a certification. 3. There was no ex (N2) working in the certification. 3510.5(f) STAFF TI Each training prognilimited to, the follow (f) Specialty areas in residents to be served, behavior managerecreation, total contechnologies; This Statute is not Surveyor: 17815 Based on interview GHMRP failed to eximple the included specialty abeing served. The findings include Review of the in-secont or other surveyor of the in-secont of the in-second of the | ficiency. See State Lember 29, 2006 It support staff (S4, Sevidence of current Covidence that 1 out of facility had current Covidence that 1 out of facility had current Covidence that 1 out of facility had current Covidence that 1 out of facility had current Covidence to the GHMR wing: I related to the | 4 nurses P and the ilimited trition, ssistive he program residents on ce of lowing | 1 229 | Cross refer to W154 and W1 adopted. | 94 and | 11/30/07 | |
| | | nunication programs ical therapy and exer | | | | | | |

| STATEMEN ND PLAN (| TOF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA MBER: | (X2) MULT A. BUILDII B. WING | IPLE CONSTRUCTION | (X3) DATE S COMPLE | | | |
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| JAME OF B | ROVIDER OR SUPPLIER | 09G058 | | | | 10/1 | 2/2007 | | |
| SYMBRA | | | 521 KENN | DDRESS, CITY, STATE, ZIP CODE NNEDY STREET, NE IGTON, DC 20011 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE | | |
| l 229 | Continued From participation of programs 3. Residents' adapt 4. Residents' diet Also see Citation II Deficiency Report | otive equipment | al W404 | I 229 | | , | | | |
| I 260 | 3512.1 RECORDK PROVISIONS Each Residence D and accurate recor this section. This Statute is not Surveyor: 17815 Based on interview failed to maintain of residents' supports | EEPING: GENERAL irector shall maintain ds and reports as rec met as evidenced by and record review, to urrent and accurate re | current quired by | I 260 | Cross refer to W104 and Wadopted. | 149 and | 11/30/07 | | |
| | record reflected all October 12, 2007, revealed that he has several times, and procedures, since hernia in June 200 appointment docur 2007. It was latered had occurred but happropriately in the On October 16, 20 agency a fax transiother items, a diag | d to ensure that Resident #2 ad been seen by GI selected as a seen by GI selected as a surgery on a few most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and the most recent GI and Total To | es. On L's record pecialists c niatal Si st 21, ional tests nted the State mong eptember | | | | | | |

| | TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | R/CLIA MBER: | (X2) MULT A. BUILDIN B. WING | | (X3) DATE S COMPL | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE |
| 1.260 | indicated that Resiseries examination hospital radiology diagnostic report windicating that it was ame day (Octobe after the procedure. It should be noted notations added to report. Whoever is same handwriting) the entries, as required 2. The facility failed survey that staff witime that he experience on a seizure report agency policies. Twas that his seizure | of the survey. The reident #2 underwent and on September 20, 20 clinic. Across the top was an 'electronic start as sent to the facility or 16, 2007), almost 10 was performed. that there were 2 hand the bottom of the diamade those entries (in had neither signed nuired by regulation. If to show evidence do howere with Residentienced a seizure on Monted the signs and syst form, in accordance the only information are had lasted 5 minutes taken to a hospital entries. | n upper GI 007 in a of the np' earlier that month dwritten agnostic a the or dated uring the t #1 at the flay 28, mptoms with vailable es and he | 1.260 | Cross refer to W104 and V adopted. | V149 and | 11/30/07 |
| | Department of Heatincluded, among of form. The form was described in greate symptoms of a sei experienced. Furt a space designate been signed by the The faxed material | 107, the facility sent to alth a fax transmittal to ther items, a seizure as dated 5/2 <sic> and are detail the signs and zure that Resident #1 her review of the form d "Signature of RN or a facility's designated its did not indicate the form (where it had be urvey ended).</sic> | hat report d revealed MD" had LPN. source of | | | | |
| | | record review reveale acility had established | | | | | |

| • | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM | | (X2) MULT A. BUILDII B. WING | | (X3) DATE SI COMPLE | TED |
|--------------------------|--|--|---|------------------------------------|---|---|--------------------------|
| VAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | DRESS CITY | STATE, ZIP CODE | 10/12 | 2/2007 |
| SYMBRA | | | 521 KENN | EDY STRE | ET, NE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETE DATE |
| I 260 | and procedure that should document e communication wit family members. | age 30 specified how facility each contact and/or h guardians and/or in ency Report - Citation | volved | 1 260 | | | |
| l 274 | Each GHMRP shall agency 's inspectic administrative recording the second (e) Signed agreem professional service. This Statute is not Surveyor: 17815. Based on record reprovide evidence of the second recording the second | ents or contracts for | uthorized ollowing /: | 1274 | A request for the neces health, resume, license agreement has been ma consultant podiatrist. Sensure that a file is marconsultants who provid the home. | and contract ade to the ymbral will intained on all | 11/30/07 |
| alth Regu | Retardation Profesthe personnel recorevealed the GHMI file for the podiatristhat this was becaupodiatrist's office, of However, after it w#1's record indicate on June 30, 2007, that the podiatrist p | Acting Qualified Ment isional (AQMRP) and ords on October 12, 20 RP failed to have con st. The AQMRP first use residents went to out in the community, as pointed out that R ed that he was "seen the AQMRP acknowl provided treatment wi was "easier for the" re | review of 007 tract on stated the esident at home" edged thin the | | | | , |
| ATE FOR | | | | 6899 | AEOI11 | If continuation | n sheet 31 of 49 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULT A. BUILDII B. WING | | (X3) DATE S COMPL | | | |
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| · | <u></u> | 09G058 | | | | 10/1 | 2/2007 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | 521 KENN | ADDRESS, CITY, STATE, ZIP CODE NNEDY STREET, NE | | | | | |
| | | | WASHING | TON, DC 2 | 20011 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETE DATE | | |
| l 274 | Continued From pa | age 31 | | 1274 | | | | | |
| | request was made all employees and | that on October 11, 2 to see personnel rec consultants, the was review for the podiat he next evening. | ords for no file | | | s. | | | |
| l 291 | 3514.2 RESIDENT | RECORDS | | I 291 | Cross refer to W260 and | adopted. | 11/30/07 | | |
| | Each record shall t signed by each ind | oe kept current, dateo ividual who makes a | d, and n entry. | | | | | | |
| | This Statute is not Surveyor: 17815 See Citation I260 a | met as evidenced by | y: | | | | | | |
| J 292 | 3514.3 RESIDENT | RECORDS | | Cross refer to I002.III.a - e and | | e and | 11/30/07 | | |
| | Each record shall i the requirements of 6-1972 (1989 Repl | nclude, but not be lin of D.C. Law 2-137, D. J. Vol.) | nited to, C. Code § | | adopted. | | | | |
| | Surveyor: 17815 | met as evidenced by section III(A-E) above | • | | | | | | |
| l 374 | 3519.5 EMERGEN | ICIES | | 1 374 | | | | | |
| | GHMRP shall pron guardian, his or he no guardian, or the sponsoring agency soon as possible, t | ces have been secur nptly notify the reside or next of kin if the reside representative of the of the resident 's st followed by written no later than forty-eight | ent's sident has e atus as otice and | | | | | | |
| | This Statute is not Surveyor: 17815 | t met as evidenced b | y : | | | • | | | |

| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | | A. BUILDIN | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADD 521 KENNI WASHING | EDY STRE | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| 374 | facility failed to noti significant changes incidents involving | and record verification of the sidents' legal gues in health condition a injuries, for the one (with a court-appointe | ardians of and/or out of two | 1 374 | Cross refer to W124 and add | opted. | 11/30/07 |
| | Conference, at app House Manager ind court-appointed gu presented the resid dated April 5, 2007 medical purposes of October 12, 2007, resident's medical document that doc | e: 7 11, 2007 Entrance proximately 11:20 AM dicated that Resident ardian. Moments lat dent's Individual Supp , in which the guardia only" was documente at 2:01 PM, review of chart revealed a cour umented the appoint an, effective July 19, | #2 had a ler, he port Plan, an "for d. On f the rt ment of | | | | |
| | incident reports revitaken to an emerge after he sustained Further review of the | 2007, at 8:21 AM, revealed that Resident ency room on May 31 an injury to his forehene incident report failed the medical guardians. | #2 was I, 2007, ead. ed to | | | | |
| | PM, interview with Retardation Profes facility's policies stresidents' families major incidents, sure and this would be creport. Notification documented on the that she would see | 2007, at approximate the Acting Qualified I sional indicated that ated that notification and guardians would uch as emergency root documented on the irror of such incidents she incident report. She written evidence the acted about the May | Mental the of follow om visits, ncident ould be se stated at the | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | A, BUILDIN | | (X3) DATE SI COMPLE | |
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| | | 09G058 | | B, WING | | 10/1 | 2/2007 |
| SYMBRAL 521 KE WASHI | | | | RESS, CITY, EDY STREI TON, DC 2 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETE DATE |
| I 374 | emergency room v the guardian was in incident was prese survey later that ev 3. On October 15, #2's medical guard | isit. No written evide nformed of the aforer nted before the end o | nentioned of the esident | T374 | | | |
| | not been informed during the past 12 Also see Federal DW124. This is a repeat de | of any unusual incide | ents tation | | | | |
| I 379 | each GHMRP shall Health, Health Factorial incident of interferes with a rearrangement, well places the resident be made by teleph followed up by write | eporting requirement in notify the Department ill notify the Department illties Division of any revent which substart sident's health, welf being or in any other tat risk. Such notificatione immediately and ten notification within ours or the next work | nt of other otially are, living way ation shall shall be | 1379 | Cross refer to W149.1 and 2 QMRP will ensure that HRA notified immediately and in within 24 hours of incident. Management Coordinator an will monitor to ensure comple | is writing Incident d QA | 10/13/07 and ongoing |
| | Surveyor: 17815 Based on interview GHMRP failed to e Health, Health Reg notified immediate | i met as evidenced by and record review, to ensure that the Depar gulation Administration by by telephone and in all incidents that place | the tment of n, was | a. | | | |

alth Regulation Administration

6899

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: | | R/CLIA MBER: | A. BUILDIN | | (X3) DATE SURVEY COMPLETED | | |
|--|---|---|---|---------------------|--|---|----------------------------|
| | <u></u> | 09G058 | | B. WING _ | | 10/1 | 2/2007 |
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| 1 379 | facility. (Residents The findings includ 1. On October 11, review of incident r 31, 2007, Resident emergency room a his forehead. The incident was report 2. According to an 22, 2007, Resident day program to a h ambulance after ex was no evidence th to HRA as required 3. According to an September 11, 200 hospital emergency stomach pain, vom incident was report September 14, 200 admitted to the host teleconference on stated that she reces staff to notify the D of the incident. Th however, to verify instructions. This is a repeat de | two of the four resider #1 and #2) e: 2007, beginning at 8: eports revealed that of #2 was taken to a hofter sustaining a lacer was no evidence the ded to HRA as required incident report dated in #1 was transported in the spital emergency rowner incident was required that this incident was required that this incident was required to the spital emergency rowner. | 20 AM, on May papital ration to lat this d. February from his om via There eported aken to a cing he on as g QMRP d her on the day idence, out her | 1 379 | Cross refer to W149.1 an QMRP will ensure that H notified immediately and within 24 hours of incide. Management Coordinator will monitor to ensure con | RA is in writing nt. Incident and QA | 10/13/07 and ongoing |
| | 3520.6 PROFESS PROVISIONS | ION SERVICES: GEI | NERAL | 1404 | | | |

| | | | | | | | : 10/31/2007 APPROVED |
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| SYMBRAL 521 KENNEDY STREET, NE WASHINGTON, DC 20011 | | | | | • | | |
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| I 404 | Each professional as appropriate, exwith a resident in professional instrict through-out the reactivities. This Statute is no Surveyor: 17815 | page 35 Il service provider shall service provider shall ach other person who the GHMRP so that rejuctions can be implemented as evidenced but met as evidenced but the shall be shall | is working belevant nented nd daily | I 404 | Cross refer to W194 an adopted. | d W436 and | 12/15/07 |

The findings include:

See Citations 1002, sections I and II, above, and the Federal Deficiency Report - Citations W194 and W436

GHMRP failed to ensure the implementation of

recommendations made by the Speech Language Therapist and Physical Therapist.

1407 3520.9 PROFESSION SERVICES: GENERAL **PROVISIONS**

> Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter.

This Statute is not met as evidenced by: Surveyor: 17815 Based on staff interview and record review, the GHMRP failed to provide evidence that the Speech Language Therapist and Physical Therapist periodically reviewed the residents' programs, for two of the two residents in the

The findings include:

sample. (Residents #1 and #2)

Resident #1's team met on March 21, 2007 to

Cross refer to W159.7, W194 and 12/15/07 W436. OMRP will ensure that

consultants that recommend formalized provide progress reports on the program implementation. Consultants will provide initial training for the goal with the QMRP providing follow-on and support

training.

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| | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
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| I 407 | review and update team had done the residents had comply physical therapy/ et 12, 2007 (more that their clinical record the consultants had monitor the implement of the implement the propert of the consultants had monitor the implement the propert of the consultants had monitor the implement the propert of the consultants had monitor the implement the propert of the consultants of the consu | his annual plan. Res same on March 6, 24 munication programs. On 6 months later), revise revealed no evidend returned to the facilinentation of the programs. It should be note ack of staff training a rograms, as written. 2. section I(A-E) and Citations W159.7, VISION SERVICES: GE | sident #2's 007. Both and n October view of ce that ity to ams or to d that the and failure Federal V194 and ENERAL articipate, | I 407 | Cross refer to W159.7, W194 W436. QMRP will ensure the consultants that recommend formalized provide progress to the program implementati Consultants will provide initi training for the goal with the providing follow-on and suppertraining. | et reports on. al QMRP | 12/15/07 | | |
| | the GHMRP's pro This Statute is not Surveyor: 17815 Based on interview minutes, the GHMi participation on the of professionals ide and procedures ma The finding include On October 12, 20 facility's policies an that the Infection C include participatio dietitian, among oti committee later tha | | w of the al revealed ould ctor and bout the e Director | | | | | | |

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| 411 | consisted of "main! Subsequent review dated August 17, 2 confirmed that mer and House Manage record review failed professionals' partibeen sought. 3521.3 HABILITAT Each GHMRP shall and assistance to resident's Indiand assistance to resident's Indiand assistance to review, the facility for training and assistance assistance assistance assistance to review, the facility for training and assistance assista | by the nurses and many of the committee's not not not not not not not not not not | ninutes 2007 f nurses /s and lat other nittee had training ce with an. /: cord itation, /ith | l 411 | Symbral will ensure that the Control Committee have of professional participation. Administration will be proceed of the meeting minute monitor quarterly to ensure compliance. | her vided a s. QA will | 12/15/07 and ongoing |
| | and #2) The findings includ 1. During observat 2007 and at breakf Resident #1 ate wit spoon with a blue a Review of the resid 2007 revealed that plastic-coated spool inquiry at 7:18 PM, spoon (pink) which resident during the in-service training of that the staff observance | tions at dinner on Octors the following more than a small (child-sized and green plastic hand lent's record on Octors he was prescribed a confor use at all meals staff presented a confort been used by a survey. Review of street working with the 11, 2007 had received | cober 10, ning, 1) metal dle. ber 12, s. Upon ated by the taff evidence resident | | Cross refer to W159 and V adopted. | /436.1 and | 12/15/07 and ongoing |

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| 1.422 | On the use of his coated teaspoon. Also see Federal Deficiency Report - Citations W159 and W436.1. | | | l 422 | * | | | | |
| | W159 and W436.1. 2. Resident #1 was observed in the home on the evening of October 10, 2007 and again the next morning, followed by day program observations and then additional observations that afternoon (October 11, 2007) in the home. At no time was the resident observed using elbow of knee pads while he moved about 'on all fours.' However, on October 12, 2007, review of Resident #1's ISP, dated March 21, 2007, revealed: "elbow and knee guards were prescribed to prevent injury to these areas of his body as he uses his elbows and knees to mobilize when indoors <client's name=""> prefers self-ambulation when indoors." At 5:10 PM, the resident said he required staff assistance with putting them on. At 7:08 PM, two direct support staff were asked about the pads. They incorrectly stated that the pads should be worn when he was out in the community. Further interview revealed that staff were unaware that he should wear them while in the home. Review of staff in-service training records revealed no evidence that the staff observed working with the resident on October 10 and 11, 2007 had received training on the use of his protective elbow and knee pads Also see Federal Deficiency Report - Citations W159 and W436.2. 3. Staff interview and review of in-service training records revealed that staff had not received training on the use of Resident #1's "Elbow Comfy Splint" that remained in it's shipping carton. Staff also confirmed that the item had been received in late May 2007, as per the date</client's> | | the next rivations iternoon time was nee pads wever, on 1's ISP, / and knee y to these s and s name> At 5:10 assistance direct s. They ne worn rther are that he teview of d no g with the ad | | Cross refer to W159 and V adopted. | 7436.2 and | 12/15/07 and ongoing | | |
| | | | | Cross refer to W159 and Vadopted. | V436.3 and | 12/15/07 and ongoing | | | |

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| Also see Federal D W159 and W436.3 4. The facility faile competency in imp shoulder exercise October 12, 2007, PT assessment, do revealed that the precommended a slinvolving the use of a pulley for program. At 7:35 and the recently-hi a shipping box that shoulder exercise review revealed the delivered in Februaresident had not us been trained on the "someone" (staff nup at a previous st training (date not sin-service training. Also see Federal D W159 and W436.3 5. The facility faile necessary informat proper implemental Resident #1's commoner of the with staff to decide questions they were started to the with staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the staff to decide questions they were started to the started | ping label. Deficiency Report - Cit. In the consure staff displayed and program using a pulle review of Resident # ated February 27, 20 hysical therapist had houlder exercise program using a pulley. Observation of a pulley. Observation of a pulley. Observation of previously indicate resident's exercise PM, two direct supported House Manager to contained Resident pulley. Further intervat (a) the pulley had leary 2007, (b) to date sed the pulley, (c) state proper use, and (d) not sure who) had not aff meeting for in-serepecified) and no add had been provided to Deficiency Report - Contained Resident and training to eation and training to eation and documentary munication training plence that the QMRP are to ask the resident resident resident and the contained to the contained | played #2's ey. On 2's annual 07, gram ons and ated the se ort staff presented #2's views and been the if had not showed vice itional odate. itations f had the nsure tion of program. had met l/or how t when | 1 422 | Cross refer to W159 an adopted. | d W436.3 and | 12/15/07 and ongoing | |
| | SUMMARY STA (EACH DEFICIENCY REGULATORY OR I Continued From parameted on the ship Also see Federal D W159 and W436.3 4. The facility faile competency in imposhoulder exercise October 12, 2007, PT assessment, do revealed that the precommended a slinvolving the use of a pulley for program. At 7:35 and the recently-hid a shipping box that shoulder exercise review revealed the delivered in Februaresident had not use the service of the services of | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY REGULATORY OR LSC IDENTIFYING INFORM. Continued From page 39 marked on the shipping label. Also see Federal Deficiency Report - Ci W159 and W436.3. 4. The facility failed to ensure staff disp competency in implementing Resident shoulder exercise program using a pulle October 12, 2007, review of Resident #PT assessment, dated February 27, 20 revealed that the physical therapist had recommended a shoulder exercise program. At 7:35 PM, two direct support and the recently-hired House Manager a shipping box that contained Resident shoulder exercise program. At 7:35 PM, two direct support and the recently-hired House Manager a shipping box that contained Resident shoulder exercise pulley. Further interview revealed that (a) the pulley had delivered in February 2007, (b) to date resident had not used the pulley, (c) stabeen trained on the proper use, and (d) "someone" (staff not sure who) had not up at a previous staff meeting for in-ser training (date not specified) and no add in-service training had been provided to Also see Federal Deficiency Report - C W159 and W436.3. 5. The facility failed to ensure that staff necessary information and training to e proper implementation and documenta Resident #1's communication training in There was no evidence that the QMRP with staff to decide upon the 10 wh and questions they were to ask the resident implementing the program. Staff were | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 marked on the shipping label. Also see Federal Deficiency Report - Citations W159 and W436.3. 4. The facility failed to ensure staff displayed competency in implementing Resident #2's shoulder exercise program using a pulley. On October 12, 2007, review of Resident #2's annual PT assessment, dated February 27, 2007, revealed that the physical therapist had recommended a shoulder exercise program involving the use of a pulley. Observations and staff interviews had not previously indicated the use of a pulley for the resident's exercise program. At 7:35 PM, two direct support staff and the recently-hired House Manager presented a shipping box that contained Resident #2's shoulder exercise pulley. Further interviews and review revealed that (a) the pulley had been delivered in February 2007, (b) to date, the resident had not used the pulley, (c) staff had not been trained on the proper use, and (d) "someone" (staff not sure who) had not showed up at a previous staff meeting for in-service training (date not specified) and no additional in-service training had been provided to date. Also see Federal Deficiency Report - Citations | ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS Continued From page 39 marked on the shipping label. Also see Federal Deficiency Report - Citations W159 and W436.3. 4. The facility failed to ensure staff displayed competency in implementation and staff interviews had not previously indicated the use of a pulley. On October 12, 2007, review of Resident #2's annual PT assessment, dated February 27, 2007, revealed that the physical therapist had recommended a shoulder exercise program involving the use of a pulley. Observations and staff interviews had not previously indicated the use of a pulley for the resident's exercise program. At 7:35 PM, two direct support staff and the recently-hired House Manager presented a shipping box that contained Resident #2's shoulder exercise pulley. Further interviews and review revealed that (a) the pulley had been delivered in February 2007, (b) to date, the resident had not used the pulley, (c) staff had not been trained on the proper use, and (d) "someone" (staff not sure who) had not showed up at a previous staff meeting for in-service training (date not specified) and no additional in-service training had been provided to date. Also see Federal Deficiency Report - Citations W159 and W436.3. 5. The facility failed to ensure that staff had the necessary information and documentation of Resident #1's communication training program. There was no evidence that the QMRP had met with staff to decide upon the 10 wh and/or how questions they were to ask the resident when implementing the program. Staff were not writing | ROVIDER OR SUPPLIER 1. STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE WASHINGTON, DC 20011 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 39 marked on the shipping label. Also see Federal Deficiency Report - Citations W159 and W436.3. 4. The facility failed to ensure staff displayed competency in implementing Resident #2's shoulder exercise program using a pulley. 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| l 422 | accordance with the program as written by the speech/ languag therapist. Staff had used a + sign to document that they asked the resident a question but did not document the resident's response, as indicated in the program. The House Manager and staff indicated that they had not received training from either the speech/ language therapist or the QMRP on how to implement the residents' communication programs. In-service training records showed no evidence that staff had received training on how to implement the residents' communication programs. Also see Federal Deficiency Report - Citation | | I 422 | Cross refer to W159.8 and a | idopted. | 12/15/07 and ongoing | |
| | W159.8. 6. The facility failed to ensure timely dental follow-up for Resident #1. On October 12, 2007, at 4:13 PM, review of Resident #1's dental record revealed that he received a dental assessment on October 4, 2006. On October 4, 2006, the dentist documented "heavy calculus deposits" and recommended "patient needs scaling will submit pre-authorization to Medicaid" The resident's record documented a return visit to the dentist on June 6, 2007, at which time the dentist found "moderate calculus deposits" and recommended "patient needs scaling will submit pre-authorization to Medicaid" Further review of the resident's record that day revealed no evidence that he received the recommended scaling, one year after it was first prescribed. Interview with the House Manager revealed that to date, the resident had not had the scaling performed and there was no return appointment | | | | Cross refer to W460 and ad | opted. | 10/26/07 and adopted |
| | 7. Resident #1 wa Instant Breakfast ii | s not observed received accordance with phy | ving ysician's | P | Cross refer to W460 and ad | opted | 10/26/07 and |

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| 1 422 | orders and there w facility on October the newly-assigned support staff said the supplement. He review revealed that not been instructed Breakfast in the rest documentation, this whether or not the supplement twice of accordance with philips through May 2007 for weight dropped to libs. through May 2007 in June 2007 a 2007. A 4 lb. loss in June 2007 a 2007. A 4 lb. loss in drop in overall body. 8. According to Redated October 1, 2 | as no Instant Breakfa 12, 2007. When inter I House Manager and the resident normally owever, interview and at the direct support of I to document the Instance is surveyor could not resident had receive daily prior to the surve hysician's orders. That Resident #1's we the had weighed 58 lbs C. After he went to the or "persistent diarrhe of lbs. He held stead 007; however, he we and dropped to 54 lbs in weight represents y weight. Pesident #2's physician 007, he was prescrib | erviewed, of direct received of record staff had stant confirm of the ey, in eight chart is, during he hospital a," his dy at 56 ighed 55 in July a 6.9% | 1 422 | Cross refer to W460 and ad | opted. | 10/26/07 |
| | dated October 1, 2007, he was prescribed Boost nutritional supplement three times daily, to be served in between meals. Observations and interviews revealed that the Boost was not being offered between meals. Instead, the resident was offered Boost immediately after he refused to finish the foods served at meals in the home and at his day program. Also see Federal Deficiency Report - Citation W460 9. Resident #2's gastro-intestinal specialist had recommended on August 21, 2007 that the head of his bed be elevated. The resident's medical chart indicated that he had ongoing problems with | | | | | and adopted | |

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FORM APPROVED TATEMENT OF DEFICIENCIES .ND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING B. WING _ 09G058 10/12/2007 IAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **521 KENNEDY STREET, NE SYMBRAL** WASHINGTON, DC 20011 SHMMARY STATEMENT OF DEFICIENCIES

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| I 422 | reflux and gastritis. Staff interviews on October 10 and 11, 2007, at 6.53 PM and 10:52 AM, respectively, observation of Resident #2's bed and bedroom on October 12, 2007, and review of his chart on October 12, 2007, beginning at approximately 9:25 AM, revealed no evidence that facility nurses ensured that the head of Resident #2's bed was kept elevated, in accordance with the gastro-intestinal specialist's August 21, 2007 recommendation. Resident #2's HMCP had been reviewed and updated by the consulting RN on September 29, 2007. However, review of the HMCP revealed that it did not reflect the gastro-intestinal specialist's August 21, 2007 recommendation to keep the head of his bed elevated. | | bed has been raise per the G.I. | 10/13/07 and ongoing |
| l 424 | Each GHMRP shall make modifications to the resident's program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation Plan; This Statute is not met as evidenced by: Surveyor: 17815 Based on observations, staff interviews and record review, the Acting Qualified Mental Retardation Professional (QMRP) failed to review and revise the Individual Program Plan (IPP) once the resident successfully completed an objective identified in the IPP, for two of the two residents in the sample. (Residents #1 and #2) | 1 424 | Cross refer to W255 and adopted. | 12/15/07 |
| | The findings include: The facility's Acting QMRP failed to revise | | | |

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| NAME OF P | ROVIDER OR SUPPLIER | | | | STATE, ZIP CODE | | | |
| SYMBRA | \L | | 521 KENI WASHING | NEDY STREET, NE STON, DC 20011 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORM | FULL | ID PREFIX TAG | PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | TION SHOULD BE THE APPROPRIATE | (X5) COMPLETE DATE | |
| 1 424 | Continued From p | page 43 | | 1.424 | | | | |
| | Resident #1's and #2's program objectives after several months of the residents' demonstrating successful completion of the objectives. | | . , | | | | | |
| | See Federal Defic | ciency Report - Citaior | n W255 | | | | | |
| 1 500 | Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. | | 1 500 | | | | | |
| | | | | | ÷ | | | |
| | Surveyor: 17815 A. Based on interfacility failed to enlegal representatives identification. | ot met as evidenced by view and record verifications the right of each we to be informed of the condition and proposition of the two residents of the two residents | cation, the resident's ne | | | | | |
| | The findings inclu | de: | , | | | | | |
| | conference, at ap House Manager in court-appointed g presented the res dated April 5, 200 medical purposes October 12, 2007 resident's medica | er 11, 2007 entrance proximately 11:20 AM ndicated that Residen uardian. Moments latident's Individual Support, in which the guardian only" was documented at 2:01 PM, review of chart revealed a couting the medical guard 2001. | t #2 had a ter, he port Plan, an "for ed. On f the rt | | Cross refer to W124 adopted. | and W148 and | 11/30/07 and ongoing | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI/ | | R/CLIA MBER: | A. BUILDIN | | (X3) DATE SURVEY COMPLETED | | |
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| | | 09G058 | · | B. WING 10/12/2007 | | | |
| | ROVIDER OR SUPPLIER | | | RESS, CITY, EDY STREI | STATE; ZIP CODE ET. NE | 1 1,546. | |
| SYMBRA - | .L. | | WASHING | TON, DC 2 | 0011 | | |
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| 1 500 | Continued From pa | ge 44 | | l 500 | | ·· <u>.</u> | |
| | of hospitalizations fithe previous year. documented visit to 2006. The resident he had undergone a hiatal hernia, and mild esophagitis, Ba and left sided colitis resident's record re- | y 19, 2006, revealed or gastric problems" The guardian's most the facility was June 's medical chart revesurgery in June 2006 had a history of GI barrett's esophagus sy Eurther review of twealed the following: | during recent 25, ealed that to repair eleeding, yndrome he | | | | |
| 1 | the abdomen performed on October 5, 2006. 2. He had undergone upper GI tests on October 24, 2006. This was 3 months after the last documented contact by the facility to the medical guardian. | | | | Cross refer to W124 and W1 | 48 and | 11/30/07 |
| , | | | | ; | adopted. | | and ongoing |
| | 2006 at which time interdisciplinary tea prepared by an outs | ce was held on Dece some members of h m met to review 3 re side entity regarding d the use of Boost n mes daily. | is ports his | | | | |
| | June 14, 2007 visit doctor refused to pr | se Manager docume to a GI clinic at whicl ovide services and r e doctor who had pe n in June 2006. | h time the eferred | | | | |
| | 26, 2007 and on Au "episodes of vomitin recommended "patielevated" and a "ba GI series" It shows specialists contacted | s to GI consultants o gust 21, 2007 (reflec- ng in June" and lent should have hea rium swallow study w uld be noted that one of by the facility since e resident because h | oted of bed with upper of the GI of then had | | | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM | | | A. BUILDII | | | (X3) DATE SURVEY COMPLETED | |
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| J 500 | Ionger accepted De The resident's recevidence that the resident's recevidence that the responsibility appointments, as of the factor of the fa | ord, however, failed to nedical guardian had ne GHMRP of the resestinal status and outlined above. 2007, at approximate the Acting Qualified I issional (AQMRP) indicated above. 2007, at approximate the Acting Qualified I issional (AQMRP) indicated the resident's medicated for the resident's medicated applicated how facility stantact and/or community of the time of the survey of the time of the survey at Resident #2 under a diagnostic report to the time of the survey at Resident #2 under a transmittal that inclused the report's conclusional transmittal that inclused the time of the survey at Resident #2 under a diagnostic report to the time of the survey at Resident #2 under a diagnostic report when the time of the survey at Resident #2 under a diagnostic report when the time of the survey at Resident #2 under a diagnostic report when the time of the survey at Resident #2 under a diagnostic report when the time of the survey at Resident #2 under a diagnostic report where the sident's medical guarder when the process of the resident is medica | ely 1:15 Mental cated that guardian cal issues and idence and ff should ication nembers). It to the ded, dated in the ey. The went an iber 20, o "nausea included rnia with mend The any dian. #2's at 2:20 ied of the | 1500 | Cross refer to W124 an adopted. | d W148 and | 11/30/07 and ongoing | |

| IDENTIFICATION NU | | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI | | A. BUILDII | TPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| 1 500 | Continued From pa | ge 46 | | l 500 | | · · · · · · | |
| | and W148 | ency Report - Citation | | | , | | |
| | B. Based on interviews and record verification, the facility failed to promote the participation of family members and/or legal guardians in the active treatment process, for two of the two residents in the sample. (Residents #1 and #2) See Federal Deficiency Report - Citation W143 C. Based on interviews and record verification, the facility failed to establish and/or implement policies that ensured the health and safety of its residents, for two of the four residents residing in the facility. (Residents #1 and #2) | | | | Cross refer to W143 and ado | pted. | 11/30/07 and adopted |
| | | | | | | | |
| · | | | | | Cross refer to W1491. and 2. and adopted. | a and b | 11/30/07 |
| | The findings include | e: | | , | | | |
| | incidents, including were reported imm review of incident-r show evidence that notified. Review of Management polici specify how facility notification. Furthe QMRP and the Inciconfirmed that ther | ting QMRP stated the injuries of unknown ediately to their administrator withe agency's incider es revealed that they staff should docume interview with the Adent Management Ce was no established a notification of their do be documented. | origin, nistrator, n failed to vas being nt did not nt said acting oordinator | | | | |
| | Citation W153 and facility failed to con incidents, including the Department of | ederal Deficiency Re Citation 1379 above. sistently report signif injuries of unknown Health and on a time dent #1's emergency | The icant origin, to ly basis. | | Cross refer to W153 and I379 adopted. | 9 and | 11/30/07 |

PRINTED: 10/31/2007

FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 09G058. 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **521 KENNEDY STREET. NE** SYMBRAL WASHINGTON, DC 20011 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1500 Continued From page 47 1500 on February 22, 2007 due to lethargy, and Resident #2's emergency room visit on May 31, 2007 after sustaining a laceration to his forehead, were not reported. 3. Cross-refer to Federal Deficiency Report -Cross refer to W154 and adopted. 11/30/07 Citation W154. The facility failed to promptly investigate Resident #2's injury, after staff presented contradictory information, to determine whether its policies prohibiting abuse and neglect had been implemented. 4. Cross-refer to Federal Deficiency Report -Cross refer to W156 and adopted. Citation W156. The facility failed to consistently 11/30/07 report the results of all incident investigations within 5 working days. For example, Resident #2's May 31, 2007 incident investigation report was dated June 21, 2007 and there was no documented evidence that the administrator had been notified of the results prior to issuance of the report. In addition, the resident's medical guardian and the Department of Health were not made aware of the incident or the investigative findings. D. Based on observation, the facility failed to implement an effective system to protect the Cross refer to W130 and adopted. 11/30/07 residents' rights for privacy during medication administration, for three of the four residents of the facility. (Residents #1, #2 and #4) The findings include: The evening medication pass was observed on October 10, 2007, beginning at 5:50 PM. The medication nurse did not protect the residents'

right to privacy during the administration of medications, as they were all gathered at the

dinner table in the dining room.

| ND PLAN (| TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION N | | R/CLIA MBER: | (X2) MULT A. BUILDIN | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| | • | 09G058 | | B. WING | | 10/1 | 2/2007 | |
| IAME OF P | ROVIDER OR SUPPLIER | | STREET ADD | RESS, CITY, | STATE, ZIP ÇODE | 10/1 | E/EUU I | |
| SYMBRA | L | | | I KENNEDY STREET, NE SHINGTON, DC 20011 | | | | |
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| 1500 | Deficiency Report, Citation W130 E. Based on residence or verification opportunities to particular of choice, to meet residents in the sate of choice, to meet residents in the sate of choice, to meet residents in the sate of choice, to meet residents in the sate of choice, to meet residents in the sate of choice, to meet residents in the sate of choice, to meet residents and play assessed interest, a weekly dance chactivity) since Mar problems accessing and other activities. 2. Resident #2's resocial or community reference. | eficiency. See Federa dated October 14, 20 lent and staff interview the facility failed to participate in communit the needs of two of the mple. (Residents #1 | ws and rovide y outings ne two and #2) #1 was leatre in his en taken to erred ed s for this reflect al choice/ | 1500 | Cross refer to W136 and ad | | 12/15/07 | |
| | | | | | | • | | |



10/12/2007

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. BUILDING B. WING _

09G058

STREET ADDRESS, CITY, STATE, ZIP CODE

NAME OF PROVIDER OR SUPPLIER SYMBRAL

521 KENNEDY STREET, NE WASHINGTON, DC 20011

| | WASHING | STON, DC | 20011 | |
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| (X4)-ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
| R 122 | 4701.2 BACKGROUND CHECK REQUIREMENT | R 122 | | |
| | Except as provided in section 4701.6, each facility shall obtain a criminal background check, and shall either obtain or conduct a check of the District of Columbia Nurse Aide Abuse Registry, before employing or using the contract services of an unlicensed person. | | | |
| | This Statute is not met as evidenced by: Surveyor: 17815 There was no evidence that the GHMRP obtained a criminal background check for one of the ten direct support staff. The personnel file for this employee (S5) indicated an initial hire date of 4/30/99; however, interview with the Acting QMRP/ Director of Nursing indicated that the employee had left the agency for a while. She was unsure of the date when the employee was rehired. There was no background check evidenced for either periods of employment. | | | |
| R 125 | 4701.5 BACKGROUND CHECK REQUIREMENT | R 125 | | |
| | The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. | | | |
| | This Statute is not met as evidenced by: Surveyor: 17815 Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. | | | |

alth Regulation Administration

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

ATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING_ 09G058 10/12/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 521 KENNEDY STREET, NE SYMBRAL WASHINGTON, DC 20011 (X4)-ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION lD (X5) COMPLETE PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) R 122 4701.2 BACKGROUND CHECK REQUIREMENT R 122 Symbral will ensure that staff provide 11/30/07 criminal back ground check for all area that and Except as provided in section 4701.6, each they have lived and worked in prior to being facility shall obtain a criminal background check, ongoing hired. The House manager will review the and shall either obtain or conduct a check of the personnel file at the administration of any District of Columbia Nurse Aide Abuse Registry, new staff (newly hired and transferred) sent before employing or using the contract services to the home within five (5) working days to of an unlicensed person. re-check and ensure compliance. QA will This Statute is not met as evidenced by: monitor quarterly to ensure compliance. Surveyor: 17815 There was no evidence that the GHMRP obtained a criminal background check for one of the ten direct support staff. The personnel file for this employee (S5) indicated an initial hire date of 4/30/99; however, interview with the Acting QMRP/ Director of Nursing indicated that the employee had left the agency for a while. She was unsure of the date when the employee was rehired. There was no background check evidenced for either periods of employment. R 125 4701.5 BACKGROUND CHECK REQUIREMENT R 125 The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Surveyor: 17815 Based on the review of personnel records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions in which the employees had worked or resided within the seven (7) years prior to the check. alth Regulation Administration

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6)-DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE COMPI | (X3) DATE SURVEY COMPLETED | |
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| 09G058 | | | ···· | B. WING | | 10/ | 10/12/2007 | |
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| SYMBRA | | | WASHING | NEDY STRE STON, DC 2 | 20011 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | (X5) COMPLETE DATE | | |
| R 125 | 2007 revealed no c criminal backgrour support staff, as fo S5 - no backgro of hire not indicate S9 - A DC check she lived in Maryland | de: connel files on Octobe evidence of comprehe nd checks for 3 of the ellows: und check document d) c was documented; h | ensive 10 direct ed (date owever, | R 125 | Cross refer to R122 and add | · | 11/30/07 | |
| | | | | | | | | |